McLaren Business Products

McLaren Print System Order

Order No: 91021
Order Date: 2024-12-20
Order Request Date:
User: Nicholas Briguglio
Phone: 5868760596

Ship Location: MULTISPECIALTY CLINIC
36500 Gratiot Suite 102
Clinton Twp, MI 48035
Brochures
Quantity: 1000
Paragon Dept No: 29070
Dept Name: MULTISPECIALTY CLINIC
Company Number:

Order Total Price: 41.00

Item Number: MM-3380-M
Item Description: Adult Patient History - Macomb
Revision Date: 05/2024
Print: 2 sided black and white
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish:
Drill: None
Poster:
Misc Info:

McLaren Macomb
ADULT PATIENT HISTORY

Patient Name: _____ Date: _____ Sex Assigned at Birth: ❑ M ❑ F Birthdate: _____

MEDICATIONS (including over-the-counter medications, herbal supplements)

ALLERGIES:

Latex/tape allergy ❑ Yes ❑ No

MEDICAL PROBLEMS

FAMILY HISTORY
If any of these relatives have had any of these conditions, please check the appropriate box.

	Father	Mother	Grandparents	Siblings/Children
Diabetes				
Cancer				
List Type(s)				
Heart Disease				
Stroke				
High blood pressure				
Seizures				
Glaucoma				
Thyroid Disease				
Kidney Disease				
Mental Illness				

PREVIOUS HOSPITALIZATIONS/SURGERIES/BLOOD TRANSFUSIONS
(Date, reason, hospital/physician)

SAFETY:

1.	Have you fallen in the last year?	❑ Yes ❑ No
2.	Do you buckle your safety belt when driving or riding?	❑ Yes ❑ No
3.	Do you wear a helmet when riding a bicycle, motorcycle, etc.	❑ Yes ❑ No
4.	Do you have current & operational smoke detectors and carbon monoxide detectors?	❑ Yes ❑ No
5.	Do you have an updated First-Aid Kit in your home?	❑ Yes ❑ No
6.	a) Do you feel safe at home?	❑ Yes ❑ No
	b) Has anyone ever	
	- hit you?	❑ Yes ❑ No
	- insulted you or put you down?	❑ Yes ❑ No
	- threatened you?	❑ Yes ❑ No
	- forced sex upon you?	❑ Yes ❑ No
	If you answered "yes" to any part of number 6, would you like help dealing with this situation?	❑ Yes ❑ No
7.	Do you keep firearms in the home?	❑ Yes ❑ No
7a.	If you answered "yes" to number 7, do you take safety precautions with firearms in the home?	❑ Yes ❑ No
8.	Do you use sunscreen regularly?	❑ Yes ❑ No

Please indicate the date of your:

Last eye exam	
Last dental exam	
Last PSA test (men)	
Last PAP (women)	
Last Mammogram	
Last Bone Density	
Last Colonoscopy	

SOCIAL HISTORY
Tobacco use (smoke, chew, or vape)? ❑ yes ❑ no If yes, what?_____ If no, have you in the past? ❑ yes ❑ no
How much? _____ per day x _____ years
Alcohol use: ❑ yes ❑ no If yes, what?_____ How much?_____ per day ____ x per week
Recreational Drugs: ❑ yes ❑ no If yes, what?_____ How much?_____ per day ____ x per week
Caffeine: ❑ yes ❑ no If yes, source _____ amount _____ per day
Exercise: ❑ yes ❑ no If yes, specify type _____ How often? _____
Occupation _____ Contact with chemicals, lead, excessive noise or blood / body fluids at work: ❑ yes ❑ no
(circle those applicable)

ADVANCE DIRECTIVES: Do you have an Advance Directive, i.e., written instructions for your family and health care provider in the event that you cannot make a decision yourself about your care? ❑ Yes ❑ No

Would you like information on Advance Directives? ❑ Yes ❑ No Info given ☐ (staff use)

(SEE REVERSE)

Spec Info: