

## McLaren Print System Order

Order No: 91335  
 Order Date: 2025-01-08  
 Order Request Date:  
 User: Kellie Roberts  
 Phone: 5864933655

Ship Location: McLaren Macomb Family First  
 36500 Gratiot Ave suite 202  
 Clinton Twp, Michigan 48035

Brochures  
 Quantity: 1000  
 Paragon Dept No: 58705  
 Dept Name: Mt Clemens Family First  
 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: \_\_\_\_\_

<p><b>MEDICATIONS</b> (including over-the-counter medications, herbal supplements)</p> <p>_____</p> <p>_____</p> <p>_____</p> <p><b>MEDICAL PROBLEMS</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p><b>PREVIOUS HOSPITALIZATIONS/SURGERIES/BLOOD TRANSFUSIONS</b> (S/M, A/S, H, A/S, P/S, I/S, V/S)</p> <p>_____</p> <p>_____</p> <p><b>SAFETY:</b></p> <p>1. Have you fallen in the last year? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>2. Do you buckle your safety belt when driving or riding? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>3. Do you wear a helmet when riding a bicycle, motorcycle, etc. <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>4. Do you have current &amp; operational smoke detectors and carbon monoxide detectors? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>5. Do you have an up-to-date First Aid Kit in your home? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>6. a) Do you feel safe at home? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p style="margin-left: 20px;">b) Has anyone ever:</p> <p style="margin-left: 40px;">- hit you? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p style="margin-left: 40px;">- insulted you or put you down? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p style="margin-left: 40px;">- threatened you? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p style="margin-left: 40px;">- forced sex upon you? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p style="margin-left: 20px;">If you answered "yes" to any part of number 6, would you like help dealing with this situation? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>7. Do you keep firearms in the home? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>8a. If you answered "yes" to number 7, do you take safety precautions with firearms in the home? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>8. Do you use sunscreen regularly? <input type="checkbox"/> yes <input type="checkbox"/> no</p>	<p><b>ALLERGIES:</b></p> <p>_____</p> <p>_____</p> <p>Latex/food allergy <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p><b>FAMILY HISTORY</b> If any of these relatives have had any of these conditions, please check the appropriate box.</p> <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <tr> <td></td> <td>Grandfather</td> <td>Father</td> <td>Mother</td> <td>Sister</td> <td>Brother</td> </tr> <tr> <td>Copd</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Cancer</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Last Type</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Heart Disease</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Stroke</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>High blood pressure</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Seizures</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Glaucoma</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Thyroid Disease</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Kidney Disease</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Mental Illness</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </table> <p>Please indicate the date of your:</p> <p>Last eye exam _____</p> <p>Last dental exam _____</p> <p>Last PSA test (men) _____</p> <p>Last PAP (women) _____</p> <p>Last Mammogram _____</p> <p>Last Bone Density _____</p> <p>Last Colonoscopy _____</p>		Grandfather	Father	Mother	Sister	Brother	Copd						Cancer						Last Type						Heart Disease						Stroke						High blood pressure						Seizures						Glaucoma						Thyroid Disease						Kidney Disease						Mental Illness					
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**SOCIAL HISTORY**

Tobacco use (smoke, chive, or pipe)  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 \_\_\_\_\_ (Print with changes, last, excessive nose or blood / body fluids at work)  yes  no

**ADVANCE** 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

**OBJECTIVES:** Would you like information on Advance Directives?  yes  no Info given  print use

(SEE REVERSE)

Spec Info: Original Poster Size