

**McLaren Print System Order**

**Order No: 45726 Reprint Previous Order No: 5695**  
**Order Date: 2019-05-30**  
**User: Kristal Johnson**  
**Phone: 810-965-8823**

**Ship Location: McLaren Flushing CMC**  
**2487 N Elms Rd**  
**Flushing, MI 48433**

**Forms**

**Quantity: 500**  
**Paragon Dept No: 63600**  
**Dept Name: McLaren Flushing CMC**  
**Company Number: 810**

**Order Total Price: 0.00**

**Item Number: MM-34320**  
**Item Description: Pediatric / Adolescent Patient History**  
**Revision Date: 10/2018**  
**Print: 2 sided black and white**  
**Paper: 20# White Text**  
**Size: 8.5 x 11**  
**Fold:**  
**Finish:**  
**Drill: None**  
**Misc Info:**

McLaren Medical Group  
**PEDIATRIC/ADOLESCENT PATIENT HISTORY**

**1. IDENTIFICATION DATA (PLEASE PRINT)**  
 Patient Name (last, first, middle initial) \_\_\_\_\_  
 Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  Male  Female

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**2. CHILD'S BIRTH HISTORY**  
*(to be completed for patient one year of age or less, or if long-term medical problems present)*  
 How long was your pregnancy? \_\_\_\_ weeks Maternal age at delivery? \_\_\_\_\_  
 How was the baby born?  Natural (Vaginal)  C-Section. If C-Section, reason: \_\_\_\_\_  
 Baby's weight at birth? \_\_\_\_ lbs \_\_\_\_ oz; length? \_\_\_\_ inches  
 Name of hospital where baby was born: \_\_\_\_\_ Condition at birth? \_\_\_\_\_  
 Was resuscitation required at birth?  Y  N

**During your pregnancy did you:**

Have high blood pressure?	<input type="checkbox"/> Y <input type="checkbox"/> N
Have protein in urine?	<input type="checkbox"/> Y <input type="checkbox"/> N
Have German measles?	<input type="checkbox"/> Y <input type="checkbox"/> N
Frequently smoke?	<input type="checkbox"/> Y <input type="checkbox"/> N
Use drugs?	<input type="checkbox"/> Y <input type="checkbox"/> N If yes, explain _____
Have sugar in urine?	<input type="checkbox"/> Y <input type="checkbox"/> N
Have urinary tract infection?	<input type="checkbox"/> Y <input type="checkbox"/> N
Take prescription medications?	<input type="checkbox"/> Y <input type="checkbox"/> N
Have a sexually transmitted disease?	<input type="checkbox"/> Y <input type="checkbox"/> N If yes, explain _____
Drink alcohol?	<input type="checkbox"/> Y <input type="checkbox"/> N If yes, explain _____
Were there any other problems during pregnancy?	<input type="checkbox"/> Y <input type="checkbox"/> N If so, what? _____
Have a positive Group B strep?	<input type="checkbox"/> Y <input type="checkbox"/> N

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**3. MEDICAL HISTORY/REVIEW OF SYSTEMS**

<input type="checkbox"/> birth defects	<input type="checkbox"/> difficulty sleeping
<input type="checkbox"/> delayed development/growth	<input type="checkbox"/> constipation
<input type="checkbox"/> attention problems	<input type="checkbox"/> diabetes
<input type="checkbox"/> depression	<input type="checkbox"/> cancer
<input type="checkbox"/> aggression	<input type="checkbox"/> kidney problems
<input type="checkbox"/> vision problems	<input type="checkbox"/> bladder problems
<input type="checkbox"/> sinus problems	<input type="checkbox"/> backstiffing
<input type="checkbox"/> hay fever	<input type="checkbox"/> seizures
<input type="checkbox"/> allergies	<input type="checkbox"/> headaches
<input type="checkbox"/> frequent nosebleeds	<input type="checkbox"/> skin problems
<input type="checkbox"/> cough	<input type="checkbox"/> bruises/bleeds easily
<input type="checkbox"/> asthma	<input type="checkbox"/> anemia
<input type="checkbox"/> heart problems	<input type="checkbox"/> frequent infections
<input type="checkbox"/> eating problems	<input type="checkbox"/> teeth/gum problems
<input type="checkbox"/> diarrhea	<input type="checkbox"/> joint/muscle problems
<input type="checkbox"/> weight problems	<input type="checkbox"/> pain (where _____)
<input type="checkbox"/> thyroid problems	<input type="checkbox"/> other _____
	<input type="checkbox"/> special diet _____

**Hospitalizations/Accidents:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Medications:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Allergies: (name of medication and reaction)** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Latex/Tape allergy?**  Y  N  
**Lead screening completed?**  Y  N  
**Immunizations:**  up-to-date  delayed/not given

**See Reverse Side**

PEDIATRIC/ADOLESCENT PATIENT HISTORY  
 000-0000-0000