McLaren Business Products

McLaren Print System Order

Order No: 52235 Reprint Previous Order No: 5695
Order Date: 2020-01-31
User: Holly Reibel
Phone: 2486273535

Ship Location: Mclaren Oakland Lake Orion ATTN: Holly
180 N. Ortonville Rd
Ortonville, Michigan 48462
Forms
Quantity: 500
Paragon Dept No: 73250
Dept Name: Mclaren Oakland Ortonville
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

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? _____
During your pregnancy did you: Was resuscitation required at birth? ☐ Y ☐ N
Have high blood pressure? ☐ Y ☐ N
Have protein in urine? ☐ Y ☐ N
Have German measles? ☐ Y ☐ N
Frequently smoke? ☐ Y ☐ N
Use drugs? ☐ Y ☐ N If yes, explain _____
Have sugar in urine? ☐ Y ☐ N
Have urinary tract infection? ☐ Y ☐ N
Take prescription medications? ☐ Y ☐ N
Have a sexually transmitted disease? ☐ Y ☐ N If yes, explain _____
Drink alcohol? ☐ Y ☐ N If yes, explain _____
Were there any other problems during pregnancy? ☐ Y ☐ N If so, what? _____
Have a positive Group B strep? ☐ Y ☐ N

3. MEDICAL HISTORY/REVIEW OF SYSTEMS
Was your child ever diagnosed with or has had:
☐ birth defects ☐ difficulty sleeping
☐ delayed development/growth ☐ constipation
☐ attention problems ☐ diabetes
☐ depression ☐ cancer
☐ aggression ☐ kidney problems
☐ vision problems ☐ bladder problems
☐ sinus problems ☐ bedwetting
☐ hay fever ☐ seizures
☐ allergies ☐ headaches
☐ frequent nosebleeds ☐ skin problems
☐ cough ☐ bruises/bleeds easily
☐ asthma ☐ anemia
☐ heart problems ☐ frequent infections
☐ eating problems ☐ teeth/gum problems
☐ diarrhea ☐ joint/muscle problems
☐ weight problems ☐ pain (where _____)
☐ thyroid problems ☐ other _____
☐ 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

Patient Name:
Date of Birth:

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