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? _____

Was resuscitation required at birth? ☐ Y ☐ N

During your pregnancy did you:

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
- ☐ delayed development/growth
- ☐ attention problems
- ☐ depression
- ☐ aggression
- ☐ vision problems
- ☐ sinus problems
- ☐ hay fever
- ☐ allergies
- ☐ frequent nosebleeds
- ☐ cough
- ☐ asthma
- ☐ heart problems
- ☐ eating problems
- ☐ diarrhea
- ☐ weight problems
- ☐ thyroid problems
- ☐ difficulty sleeping
- ☐ constipation
- ☐ diabetes
- ☐ cancer
- ☐ kidney problems
- ☐ bladder problems
- ☐ bedwetting
- ☐ seizures
- ☐ headaches
- ☐ skin problems
- ☐ bruises/bleeds easily
- ☐ anemia
- ☐ frequent infections
- ☐ teeth/gum problems
- ☐ joint/muscle problems
- ☐ pain (where _____)
- ☐ 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:

4. HEALTH RISK ASSESSMENT (PLEASE CHECK ALL THAT APPLY TO PATIENT)

☐ Wears bike helmet
☐ Wears knee/elbow pads
☐ Seat belt use
☐ Has healthy eating habits
☐ Uses sunscreen
☐ Exercises regularly
☐ Drinks alcohol
☐ Is sexually active
☐ Uses drugs
☐ Firearms in the home
☐ Has severe mood swings
☐ Is approriately concerned for personal safety
☐ Smokes/Smokers in house
☐ Lives in (or often visits) house built in 1978 or earlier

5. FAMILY HISTORY

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

	Mother	Father	Sister/Brother	Maternal Grandparents	Paternal Grandparents	COMMENTS:
Allergies						
Birth defects						
Blood disease						
Bone or joint disorders						
Cancers or malignancies						
Asthma, chonic bronchitis						
Eye/ear disorders						
Diabetes						
Heart problems						
Kidney or bladder disease						
Mental retardation						
Muscular weakness/poor control						
Cerebral palsy/epilepsy						
Psychiatric condition						
Rheumatic fever						
Thyroid disease						
Tuberculosis						
Sexually transmitted disease						
Other (explain:_____)						

6. SOCIAL HISTORY

Patient (child) lives with:

☐ Parents ☐ Parents and siblings
☐ Mother ☐ Father
☐ Other: _____

Patient attends:

☐ Day Care ☐ School

What pets do you have in your house? ☐ Not Applicable

_____
_____

Other Concerns:

_____
_____
_____
_____

Physician's Notes:

_____
_____
_____
_____

_____ **Date:** ____ / ____ / ____
Signature of Parent/Legal Guardian

_____ **Date/Time:** _____
Signature of Physician

Patient Name:

Date of Birth: