

McLaren Print System Order

Order No: 7068
 Order Date: 2014-11-11
 User: Pamela Dietrich
 Phone: 810 953 6400

Ship Location:
 2313 East Hill Road
 Grand Blanc, MI 48439

Forms
 Quantity: 500
 Paragon Dept No: 64050
 Dept Name: 64050
 Company Number: 810

Order Total Price: 0.00

Item Number: MM-34320
 Item Description: Pediatric / Adolescent Patient History
 Revision Date: 9/2013
 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) _____
 Birth date ____ / ____ / ____ 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:
 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: <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"/> bedwetting <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"/> tooth/gum problems <input type="checkbox"/> diarrhea <input type="checkbox"/> orthopedic problems <input type="checkbox"/> weight problems <input type="checkbox"/> pain (where _____) <input type="checkbox"/> thyroid problems <input type="checkbox"/> other _____ <input type="checkbox"/> _____ <input type="checkbox"/> special diet _____	Hospitalization/accidents _____ _____ _____ Medications _____ _____ Allergies (name of medication and reaction) _____ Lifetime allergy? <input type="checkbox"/> Y <input type="checkbox"/> N Lead screening completed? <input type="checkbox"/> Y <input type="checkbox"/> N Immunizations: <input type="checkbox"/> up-to-date <input type="checkbox"/> delayed/not given
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See Reverse Side

PEDIATRIC/ADOLESCENT PATIENT HISTORY
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