

**McLaren Print System Order**

Order No: 8986 Reprint Previous Order No: 5695  
 Order Date: 2015-02-12  
 User: Rebecca Colburn  
 Phone: 810 496-2507

Ship Location: McLaren Flint - Fenton CMC Attn: Rebecca  
 2420 Owen Rd.  
 Fenton , MI 48430

**Forms**

Quantity: 500  
 Paragon Dept No: 64000  
 Dept Name: MMG McLaren Flint Fenton CMC  
 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

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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? \_\_\_\_\_  
 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

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**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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