

McLaren Print System Order

Order No: 48401 Reprint Previous Order No: 5695  
Order Date: 2019-09-04  
User: Dawn Caspers  
Phone: 248-674-0388

Ship Location: Attn Dawn Caspers  
3901 Highland Suite D  
Waterford , MI 48328

Forms

Quantity: 500  
Paragon Dept No: 73650  
Dept Name:  
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"/> back/aching
<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 \_\_\_\_\_

PEDIATRIC/ADOLESCENT PATIENT HISTORY  
MM-34320-01