

McLaren Print System Order

Order No: 55408 Reprint Previous Order No: 5695
 Order Date: 2020-07-15
 User: colleen taraskavage
 Phone: 810-658-6503

Ship Location: MMG Davison Community Medical Center
 10090 E. Lippincott Blvd
 Davison, Michigan 48423

Forms

Quantity: 500
 Paragon Dept No: 50002
 Dept Name: MMG Davison CMC
 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

I. IDENTIFICATION DATA (PLEASE PRINT)
 Patient Name (last, first, middle initial) _____
 Birthdate ____/____/____ Sex Male Female

II. 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 |

III. 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"/> back/neck 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"/> 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

[See Reverse Side](#)

PEDIATRIC/ADOLESCENT PATIENT HISTORY
 06/2008 (11/18)