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
☐ Has severe mood swings
☐ Is appropriately concerned for personal safety
☐ Smokes/Smokers in house
☐ Lives in (or often visits) house built in 1978 or earlier
☐ Firearms in the home
☐ Safety precautions taken for firearms

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						
List types						
Asthma, chronic bronchitis						
Eye/ear disorders						
Diabetes						
Heart problems						
Kidney or bladder disease						
Intellectual Disability						
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: