

McLaren Print System Order

Order No: 67780 Reprint Previous Order No: 5695
Order Date: 2022-02-17
User: Leah Blair
Phone: 989-826-3271

Ship Location: Primary Care Att Beth
2990 Campbell Rd
Rose City , MI 48654

Forms

Quantity: 100
Paragon Dept No: 69250
Dept Name: Primary Care
Company Number: 810

Order Total Price: 0.00

Item Number: MM-34320
Item Description: Pediatric / Adolescent Patient History
Revision Date: 9/2020
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

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

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"/> backstiffing
<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
 09/2020 01/20