

McLaren Print System Order

Order No: 73055 Reprint Previous Order No: 5695
Order Date: 2022-10-19
User: Jean OHalloran
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Ship Location: McLaren Oakland Oxford Family Medicine
385 N. Lapeer Road
Oxford, MI 48371

Forms

Quantity: 100
Paragon Dept No: 73600
Dept Name: Oxford Family Medicine
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

<p>Was your child ever diagnosed with or has had:</p> <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 _____	<p>Hospitalizations/Accidents: _____ _____</p> <p>Medications: _____ _____</p> <p>Allergies: (name of medication and reaction) _____ _____</p> <p>Latex/Tape 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</p> <p style="text-align: center;">See Reverse Side</p>
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 09/2020 01/20