

McLaren Print System Order

Order No: 77064 Reprint Previous Order No: 5695
Order Date: 2023-05-03
User: TINA PLAUTZ
Phone: 248-922-9975

Ship Location: McLaren Oakland Clarkston Internal Medicine
6507 Town Center Dr, Suite A
Clarkston, MI 48346

Forms

Quantity: 500
Paragon Dept No: 73150
Dept Name: Clarkston Internal 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 smoked? | <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"/> 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
09/2020 01/20