McLaren Business Products

McLaren Print System Order

Order No: 46009 Reprint Previous Order No: 5695
Order Date: 2019-06-05
User: Daniela Dimovski
Phone: 5869788010

Ship Location: Sterling Hts Peds & Family
35111 Dodge Park
Sterling Hts, MI 48312
Forms
Quantity: 500
Paragon Dept No: 72500
Dept Name: Sterling Hts Peds & Family
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

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

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