

## McLaren Print System Order

Order No: 49230 Reprint Previous Order No: 5695  
 Order Date: 2019-10-04  
 User: Kimberly Gunsell  
 Phone: 989-316-4272

Ship Location: McLaren Bay Family Medicine  
 3720 Katalin Ct., Suite 201  
 Bay City, MI 48706

### Forms

Quantity: 500  
 Paragon Dept No: 69000  
 Dept Name:  
 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

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**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

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**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  
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