

**McLaren Print System Order**

Order No: 58385 Reprint Previous Order No: 5695  
 Order Date: 2020-11-12  
 User: Dorothy Craig  
 Phone: 5176474166

Ship Location: McLaren MMP Portland Family Care  
 406 Kent St.  
 Portland, MI 48875

**Forms**

Quantity: 500  
 Paragon Dept No: 68375  
 Dept Name: MGL MMP Portland Family 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

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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 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

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**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"/> bladder 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><b>Hospitalizations/Accidents:</b>                  _____                  _____</p> <p><b>Medications:</b>                  _____                  _____</p> <p><b>Allergies: (name of medication and reaction)</b>                  _____                  _____</p> <p><b>Latex/Tape allergy?</b> <input type="checkbox"/> Y <input type="checkbox"/> N  <b>Lead screening completed?</b> <input type="checkbox"/> Y <input type="checkbox"/> N  <b>Immunizations:</b> <input type="checkbox"/> up-to-date <input type="checkbox"/> delayed/not given</p> <p style="text-align: center;"><b>See Reverse Side</b></p>
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 09/2020 01/20