McLAREN MEDICAL GROUP
CHILD/ADOLESCENT REGISTRATION

Language Preference: ☐ English
☐ Other specify: _____

PATIENT INFORMATION

PATIENT NAME (Last) (First) (Middle)	❑ Male ❑ Female	LANGUAGE: ❑ English ❑ Spanish ❑ Arabic ❑ German ❑ Polish ❑ French ❑ Italian ❑ Chinese ❑ Declined	ETHNICITY: ❑ Hispanic/ Latino ❑ Non-Hispanic/ Latino ❑ Decline to Answer ❑ Unknown	RACE: ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ White Caucasian ❑ Native Hawaiian or Pacific Islander ❑ Unknown or Decline to Answer
ADDRESS CITY STATE ZIP CODE				
TELEPHONE ( )	SS# — —	BIRTH DATE — —		
PRIMARY CARE PHYSICIAN	REFERRED OR RECOMMENDED BY			

PARENT/GUARDIAN _____ **RELATIONSHIP**

PARENT/GUARDIAN _____ **RELATIONSHIP**

For appointment reminders only, use phone number _____ and E-mail _____

For leaving a message, use phone number _____

PARENT/GUARDIAN INFORMATION

NAME	
ADDRESS	
CITY STATE ZIP	
TELEPHONE ( )	BIRTH DATE — —
SS# — —	CELL PHONE
E-MAIL ADDRESS	
EMPLOYER	OCCUPATION
EMPLOYER ADDRESS	
EMPLOYER TELEPHONE ( )	HOW LONG EMPLOYED

NAME	
ADDRESS	
CITY STATE ZIP	
TELEPHONE ( )	BIRTH DATE — —
SS# — —	CELL PHONE
E-MAIL ADDRESS	
EMPLOYER	OCCUPATION
EMPLOYER ADDRESS	
EMPLOYER TELEPHONE ( )	HOW LONG EMPLOYED

INSURANCE INFORMATION

PRIMARY INSURANCE		SUBSCRIBER	BIRTH DATE
POLICY #	GROUP #	EMPLOYEE ID#/SS#/MISC	GROUP NAME

SECONDARY INSURANCE		SUBSCRIBER	BIRTH DATE
POLICY #	GROUP #	EMPLOYEE ID#/SS#/MISC	GROUP NAME

OTHER INFORMATION

NEAREST RELATIVE NOT RESIDING AT SAME ADDRESS

NAME		RELATIONSHIP	
ADDRESS	CITY	STATE	ZIP CODE
WORK TELEPHONE ( )		HOME TELEPHONE ( )	
EMERGENCY CONTACT	RELATIONSHIP	TELEPHONE ( )	

PARENT/LEGAL GUARDIAN SIGNATURE	**DATE**

UPDATES

DATE	SIGNATURE	DATE	SIGNATURE

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:

4. HEALTH RISK ASSESSMENT (PLEASE CHECK ALL THAT APPLY TO PATIENT)

- ☐ Wears bike helmet
- ☐ Wears knee/elbow pads
- ☐ Seat belt use
- ☐ Has healthy eating habits
- ☐ Uses sunscreen
- ☐ Exercises regularly
- ☐ Drinks alcohol
- ☐ Is sexually active
- ☐ Uses drugs
- ☐ Has severe mood swings
- ☐ Is appropriately concerned for personal safety
- ☐ Smokes/Smokers in house
- ☐ Lives in (or often visits) house built in 1978 or earlier
- ☐ Firearms in the home
- ☐ Safety precautions taken for firearms

5. FAMILY HISTORY

If relatives have had any of these conditions, please check the appropriate box.

	Mother	Father	Sister/Brother	Maternal Grandparents	Paternal Grandparents	COMMENTS:
Allergies	☐	☐	☐	☐	☐	
Birth defects	☐	☐	☐	☐	☐	
Blood disease	☐	☐	☐	☐	☐	
Bone or joint disorders	☐	☐	☐	☐	☐	
Cancers or malignancies	☐	☐	☐	☐	☐	
List types	☐	☐	☐	☐	☐	
Asthma, chronic bronchitis	☐	☐	☐	☐	☐	
Eye/ear disorders	☐	☐	☐	☐	☐	
Diabetes	☐	☐	☐	☐	☐	
Heart problems	☐	☐	☐	☐	☐	
Kidney or bladder disease	☐	☐	☐	☐	☐	
Intellectual Disability	☐	☐	☐	☐	☐	
Muscular weakness/poor control	☐	☐	☐	☐	☐	
Cerebral palsy/epilepsy	☐	☐	☐	☐	☐	
Psychiatric condition	☐	☐	☐	☐	☐	
Rheumatic fever	☐	☐	☐	☐	☐	
Thyroid disease	☐	☐	☐	☐	☐	
Tuberculosis	☐	☐	☐	☐	☐	
Sexually transmitted disease	☐	☐	☐	☐	☐	
Other (explain:_____)	☐	☐	☐	☐	☐	

6. SOCIAL HISTORY

Patient (child) lives with:

☐ Parents ☐ Parents and siblings

☐ Mother ☐ Father

☐ Other: _____

Patient attends:

☐ Day Care ☐ School

What pets do you have in your house? ☐ Not Applicable

_____

_____

Other Concerns:

_____

_____

_____

_____

Physician's Notes:

_____

_____

_____

_____

_____ **Date:** ____ / ____ / ____

Signature of Parent/Legal Guardian

_____ **Date/Time:** _____

Signature of Physician

Patient Name:

Date of Birth: