

PROBATE COURT OF FRANKLIN COUNTY, OHIO

IN THE MATTER OF _____

CASE NO. _____

CASE HISTORY OF MENTAL RETARDATION

This form must accompany Medical Certificate of State Institution. To be completed by examining physician, deputy or other person designated by the court.

1. Name _____ Birthdate _____ Social Security No. _____

2. Sex _____ Single Married Widowed Divorced Separated Religion _____

3. Place of Residence _____ County of legal residence _____

4. Name and address of person designated net of kin _____
_____ Phone No. _____ Relationship _____

5. Name and address of family doctor _____

6. Name and address of any other doctors, clinics, or hospitals having had contact with this case and the nature of that contact _____

7. Reason for commitment at this time _____

8. Father's name and address _____

9. Mother's name and address _____

10. List any blood relatives who have a history of convulsions, mental retardation or admission to a public or private hospital for mental illness or mental retardation, giving place and date: _____

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11. Did mother have any illness during pregnancy? Yes No If yes, describe. _____

12. Was baby full term? Yes No Birth weight _____ Oxygen used? Yes No

Describe: _____

13. Was there any difficulty with the birth? _____ Describe fully: _____

14. What and when were the first signs of retardation noted? Describe fully: _____

15. At what age did the patient walk? _____ Talk? _____

16. Can patient walk without assistance? _____

17. Is patient toilet trained? Yes No Describe: _____

18. At what age was patient toilet trained for urine? _____ Bowels? _____

19. Can patient feed self with spoon? Yes No Describe: _____

20. Can patient dress self (work zipper, button clothes, tie shoes)? Describe: _____

21. Has patient had serious accidents or injuries? Yes No Describe fully and give age at occurrence: _____

22. Has patient had serious illnesses or operations? Yes No Describe fully and give age of occurrence: _____

23. Has patient had convulsions, fainting, blackouts or spasms? Yes No At what age? _____

Describe fully: _____

24. Is patient presently on medication? Yes No List medication and dosage: _____

25. List any drugs, which have caused difficulty (allergy): _____

26. Is there any defect of hearing and vision? Yes No Describe: _____

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27. Has the patient had the following diseases and immunizations?

Disease	When patient had disease	Dates of Immunizations
Measles	_____	_____
Mumps	_____	_____
Smallpox	_____	_____
Diphtheria	_____	_____
Whooping Cough	_____	_____
Tetanus	_____	_____
Polio	_____	_____

28. Check following behavior traits, if present:

Fire Setting Aggressive Sexual Misconduct Stealing Combative Withdrawn

29. Has patient ever been to school? Yes No If yes, name and location of school _____

What grades? _____ Special education classes? _____

30. If excluded, give dates and reasons: _____

31. Has patient ever been tested psychologically? Yes No Give dates: _____

Where tested? _____ I.Q. scores, if known: _____

32. Has patient ever worked for pay? Yes No Describe: _____

33. Has patient ever lived in place other than his/her own home? Yes No Please give dates, names and addresses: _____

34. Has patient been told why he/she is being brought to an institution? Yes No

The above information furnished by _____

Address _____

Relationship to patient _____

This information is true to the best of my knowledge.

Signature