

**PROBATE COURT OF FRANKLIN COUNTY, OHIO**  
**LAWRENCE A. BELSKIS, JUDGE**

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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

CASE NO. \_\_\_\_\_

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: \_\_\_\_\_

CASE NO. \_\_\_\_\_

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

<b>Disease</b>	<b>When patient had disease</b>	<b>Dates of Immunizations</b>
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