REVIEW OF THE MEDICAL HISTORY
State of Michigan Protocols
to Determine Cause and Manner of a Sudden and Unexplained Child Death

Investigator: Obtain Medical Records and Protective Services Records

CHILD'S HEALTH

1. Name of Child:

2. Case Number:

3. Name(s) of Child's Health Care Provider:

Phone Numbers:

4. Has Child Had an Illness in the Last Two Weeks: ☐ No ☐ Yes Since When:

☐ Fever	☐ Cough	☐ Pneumonia	☐ Vomiting
How High:_____	☐ Runny Nose	☐ Appetite Changes	☐ Rashes
☐ Fussiness	☐ Congestion	☐ Diarrhea	☐ Colic
☐ Sniffles	☐ Wheezing	☐ Constipation	☐ Other

5. Was Child Taken for Treatment: ☐ No ☐ Yes

Where:

6. Did Child Receive Any Medication 48 Hours Prior to Death: ☐ No ☐ Yes

☐ Aspirin	☐ Advil	☐ Antibiotics	☐ Folk Remedy
☐ Tylenol	☐ Cold Medicine	☐ Anticonvulsant	☐ Other

7. Has Child Been Exposed to Any Ill Persons or Pets Recently: ☐ No ☐ Yes

If Yes, Explain:

8. Has Child Received Well Visits and Immunizations: ☐ No ☐ Yes

Are Immunizations Up To Date: ☐ No ☐ Yes

9. Has Child Had Any Serious Illness or Injury in the Past: ☐ No ☐ Yes

☐ Lung Disease	☐ Apnea	☐ Fractures	☐ Other Illness
☐ Heart Disease	☐ Seizures	☐ Head Injuries	☐ Other Injuries

10. Has Child Ever Been Hospitalized: ☐ No ☐ Yes Why:

Where:

11. Is There any Family (Immediate or Extended) History of:

☐ Accidents	☐ Mental Illness	☐ Prematurity	☐ Congenital Anomalies
☐ Infections	☐ Pneumonia	☐ Severe Trauma	☐ Other
☐ Abuse or Neglect			

Explain:

12. Describe any Recent Travel By Child or Caretakers:

Endorsed by the Michigan Association of Medical Examiners, Michigan State Police, Michigan Association of Chiefs of Police, Michigan Sheriffs' Association, Prosecuting Attorneys Association of Michigan, Michigan Department of Community Health, Michigan Family Independence Agency, Michigan SIDS Alliance

13. Is There Any History of SIDS or Other Child Death Involving Parents or Caregivers: ☐ No ☐ Yes

If Yes, Explain in Narrative Including Dates, Cause and Manner, Location.

FEEDING HISTORY

14. Time Child Last Ate: What Was Fed: Amount in Ounces:

Any Difficulties:

15. If Infant, Is Child Usually: ☐ Bottle Fed ☐ Breastfed ☐ Any Difficulties:

16. Any Known Food Intolerances, Allergies, Reactions to Immunizations: ☐ No ☐ Yes

Describe:

17. Has Child Recently Had:

☐ Cow's Milk ☐ Honey ☐ Watered Down Formula

☐ Goat's Milk ☐ Nut Products ☐ Eggs

BIRTH HISTORY

18. Where Was Child Born: Difficulty At Delivery: ☐ No ☐ Yes

Type of Delivery:

19. Birth Weight: Full Term or Gestational:

20. Any Congenital Anomalies at Birth: ☐ No ☐ Yes Describe:

21. Regular Prenatal Visits: ☐ No ☐ Yes

22. Any Complications of Pregnancy or Maternal Health Problems: ☐ No ☐ Yes

If Yes, Explain:

23. Was Mother Taking Medications for Above Conditions: ☐ No ☐ Yes

24. During Pregnancy, was Mother Taking Any:

☐ Alcohol ☐ Heroin ☐ Tobacco ☐ Unknown

☐ Cocaine ☐ Marijuana ☐ Other

NARRATIVE