



PHOENIX PEDIATRICS, LTD.

INFANCY, CHILDHOOD, ADOLESCENCE HISTORY

(PLEASE PRINT)

DATE: _____

I.

Child's Name _____ (last) (first)

Previously Seen/Treated By _____ (Name of Doctor)

Date of Birth _____ M F (circle)

Address _____ (Street)

Child Lives With _____ (Fill in mother, father, parents, etc.)

(City) (State) (Zip)

Address _____ (Street)

Child's School _____ (Name)

(City) (State) (Zip)

Child's AHCCCS I.D. Number _____

Telephone No. _____

II.

CHILD'S BIRTH HISTORY

During your pregnancy with this child, did you: _____

- 1. Have high blood pressure? YES NO
- 2. Have diabetes or suger in your urine? YES NO
- 3. Have albumin or protein in your urine? YES NO
- 4. Have a urinary infection? YES NO
- 5. Have German (3 day) measles? YES NO
- 6. Take any medicines? YES NO
- 7. Smoke cigarettes? YES NO

Circle One

- 8. Get treatment for gonorrhea or syphilis? YES NO
- 9. Drink alcohol? YES NO
- 10. How long was your pregnancy? _____ months
- 11. How early did you start seeing the doctor? _____ month
- 12. Have this child early (premature)? YES NO
- 13. Have more than one baby delivered? YES NO
- 14. Have a difficult labor/delivery? YES NO
- Was it a breech (bottom first) delivery? YES NO
- Was it a cesarean delivery? YES NO

Circle One

III.

CHILD'S PAST/PRESENT MEDICAL/NUTRITIONAL HISTORY

- 1. Did your baby breathe/cry immediately at birth?..... YES NO
- 2. Was the baby jaundice at birth? YES NO
- 3. Did the baby have an RH problem? YES NO
- Receive blood? YES NO
- 4. At birth, did the baby appear normal? YES NO
- 5. Was Sickle Cell Testing done at birth? YES NO
- 6. Was PKU Testing done at birth? YES NO
- 7. During baby's FIRST year, did you breast feed? ... YES NO
- How long? _____

Circle One

- 8. During baby's FIRST year did you formula feed? YES NO
- How long? _____
(Weeks/Months)
- 9. If feeding problems, explain _____
- 10. Weaning from breast completed at _____
(Child's Age)
- 11. Whole milk started at _____
(Age)
- Problems/Allergies? _____
- 12. Solid food started at _____
(Age)
- Problems/Allergies? _____

Circle One

INFANCY, CHILDHOOD, ADOLESCENCE HISTORY (CONTINUED)

IV. IMPORTANT MEDICAL INFORMATION

ILLNESS ACCIDENT SURGERY	COMPLICATIONS SEVERITY	ALLERGIC REACTIONS TO DRUGS FOOD?	AGE OF CHILD
1.			
2.			
3.			
4.			

V. IMMUNIZATION INFORMATION

NAME	DATES (If Known)					REACTIONS
1. DPT						
2. DT						
3. TOPV (Polio Vaccine)						
4. MMR (Mumps, Measles, Rubella)						
5. T.B. (TEST)						

VI. SOCIAL/DEVELOPMENTAL HISTORY

- | | |
|---|---|
| 1. Child has how many sisters _____ brothers? _____ | 5. Child sat up at _____ (age) |
| 2. Child is _____ in family? (oldest, youngest, middle) | 6. Child crawled at _____ (age) |
| 3. Who spends most time caring for child? _____ (mother, father, etc) | 7. Child walked at _____ (age) |
| 4. Does child go to day care, baby sitter or preschool on a regular basis? Circle One: YES NO | 8. Child started talking at _____ (age) |

VII. FAMILY HISTORY

Has any blood relative of your child never had or been treated for

	Circle One		Circle One
Allergies	YES NO	Heart trouble	YES NO
Blood disease	YES NO	Diabetes (Sugar in urine)	YES NO
Cancer	YES NO	Tuberculosis (T.B.)	YES NO
Lung disease	YES NO	Mental illness	YES NO

VIII. CONCERNS/PROBLEMS

Does your baby/child have any on-going problem that concerns you? If yes, put an X in box

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Eats too little | <input type="checkbox"/> Eats too much | <input type="checkbox"/> Speaks unclearly | <input type="checkbox"/> Always has runny nose and /or cough |
| <input type="checkbox"/> Cries a lot | <input type="checkbox"/> Has frequent temper tantrums | <input type="checkbox"/> Doesn't always respond to noise or spoken word | <input type="checkbox"/> Sees poorly |
| <input type="checkbox"/> Won't sleep | <input type="checkbox"/> Frequently constipated | <input type="checkbox"/> Seems small for age | <input type="checkbox"/> Wets bed |
| <input type="checkbox"/> School problems | <input type="checkbox"/> Behavior Problems | | |
| <input type="checkbox"/> Are there any other problems? Please write them down _____ | | | |

SIGNATURE: _____
(parent, guardian, caretaker)

REVIEWED BY _____
(D.R. P.A., NURSE)