PHOENIX PEDIATRICS, LTD.

INFANCY, CHILDHOOD, ADOLESCENCE HISTORY

(PLEASE PRINT)

DATE: ____________________

I.

Child's Name ____________________ ____________________
(last) (first)

Date of Birth ____________________ M F *(circle)*

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

Address ____________________
(Street)

____________________ ____________________ ____________________
(City) (State) (Zip)

Telephone No. ____________________

Previously Seen/Treated By ____________________
(Name of Doctor)

Address ____________________
(Street)

____________________ ____________________ ____________________
(City) (State) (Zip)

Child's School ____________________
(Name)

Child's AHCCCS I.D. Number ____________________

II. CHILD'S BIRTH HISTORY

During your pregnancy with this child, did you:

	Circle One	
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

III. CHILD'S PAST/PRESENT MEDICAL/NUTRITIONAL HISTORY

	Circle One	
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? ____________________

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? ______
2. Child is ____________ in family? (oldest, youngest, middle)
3. Who spends most time caring for child? ____________ (mother, father, etc)
4. Does child go to day care, baby sitter or preschool on a regular basis? Circle One: YES NO
5. Child sat up at ______ (age)
6. Child crawled at ______ (age)
7. Child walked at ______ (age)
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

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

SIGNATURE: ____________ (parent, guardian, caretaker)

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