



Arizona Institute
of Medicine & Pediatrics

PEDIATRIC CONFIDENTIAL PERSONAL HEALTH HISTORY

PATIENT NAME: _____ DATE OF BIRTH: _____

PRIMARY CARETAKER: _____ RELATIONSHIP: _____

Please answer the following questions thoroughly and to the best of your ability. If you are not certain of the appropriate response to a question, please discuss it further with your physician. If the answer is "none", circle NONE.

PRIMARY CONCERNS FOR THIS OR FUTURE APPOINTMENTS:

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

ALLERGIES/ MEDICATION REACTIONS: NONE

MEDICATION NAME	DESCRIBE REACTION

BIRTH HISTORY (FOR CHILDREN LESS THAN 5 YEARS OF AGE AT TIME OF INITIAL VISIT):

- GESTATIONAL AGE: Term Preterm (# of weeks at birth: _____)
- TYPE OF DELIVERY: Vaginal (Circle One: Spontaneous | With Forceps | With Vacuum)
 C-section
- COMPLICATIONS: During Pregnancy (if any): _____
 During Delivery (if any): _____
 After Delivery (if any): _____
- BIRTH WEIGHT: _____ BIRTH LENGTH: _____ HEAD CIRCUMFERENCE: _____
- HEARING TEST: Passed Failed
- HEPATITIS B SHOT AT BIRTH: Yes No
- PKU TEST AT BIRTH: Yes No

PAST MEDICAL HISTORY: NONE (CHECK ALL CONDITIONS OR SYMPTOMS YOU HAVE HAD DIAGNOSED OR TREATED)

CONDITION	ONGOING?	DATE BEGAN	CONDITION	ONGOING?	DATE BEGAN
<input type="checkbox"/> Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
<input type="checkbox"/> Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Kidney Failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
<input type="checkbox"/> Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
<input type="checkbox"/> Bedwetting	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
<input type="checkbox"/> Behavior Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Skin Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
<input type="checkbox"/> Chronic Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Sleeping Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
<input type="checkbox"/> Constipation	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
<input type="checkbox"/> Cystic Fibrosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Ulcerative Colitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
<input type="checkbox"/> Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Undescended Testicle	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Vision Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Warts	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	<input type="checkbox"/> Other (list all):		_____
<input type="checkbox"/> Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____			_____
<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____			_____
<input type="checkbox"/> Heartburn	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____			_____
<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____			_____
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____			_____



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LIST ALL PREVIOUS SURGERIES AND HOSPITALIZATIONS: NONE

SURGERY/HOSPITALIZATION	PHYSICIAN/SURGEON	MONTH/YEAR

LIST CURRENT MEDICATIONS: NONE

*** Including over-the-counter medications, such as vitamins, pain relievers, laxatives, and naturopathic preparations such as herbs and teas.

MEDICATION NAME	STRENGTH OR DOSE	FREQUENCY

LIST ALL HEALTHCARE PROVIDERS WHO HAVE TAKEN CARE OF YOU IN THE LAST THREE (3) YEARS: NONE

PHYSICIAN NAME	SPECIALTY/YEAR	CITY/STATE	CONDITION TREATED

FAMILY HISTORY: NONE (LIST ALL CHRONIC MEDICAL CONDITIONS IN THE IMMEDIATE FAMILY)

Allergies Yes No Cancer Yes No Lung Disease Yes No
 Asthma Yes No Diabetes Yes No Mental Illness Yes No
 Blood Disease Yes No Heart Trouble Yes No Tuberculosis Yes No
 Other: _____

SOCIAL/DEVELOPMENT HISTORY:

Father's Age: _____ Child's Birthplace: _____ Child sat up at: _____ mos
 Mother's Age: _____ Child's Hobbies: _____ Child crawled at: _____ mos
 Siblings' Age(s): _____ Pets: _____ Child walked at: _____ mos
 Smoking in the home? Yes No Attends Daycare? Yes No Sentences used at: _____ mos

YEAR OF LAST INJECTION OR TEST:

_____ Bone Scan (Osteoporosis)	_____ Flu Vaccine	_____ Pulmonary Function Test
_____ Cardiac Catheterization	_____ Hepatitis A Vaccine	_____ Sigmoidoscopy
_____ Chest X-ray	_____ Hepatitis B Vaccine	_____ Stool for Occult Blood
_____ Cholesterol Test	_____ MMR Vaccine	_____ TB Skin Test
_____ Colonoscopy	_____ Pneumonia Vaccine	_____ Tetanus Vaccine
_____ EKG	_____ PSA Test	_____ Treadmill for Heart

PSYCHOLOGIC HISTORY: Please indicate if your child has now or in the past has ever experienced the following:

C= CURRENT P= PAST N= NONE

Depression: _____ Mania/ Psychosis _____ Sexual Abuse _____ Physical Abuse _____ Suicidal/ Homicidal Thoughts _____