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 Vaccuum)
❑ 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
❑ Allergies	❑ Yes	❑ No	_____
❑ Anemia	❑ Yes	❑ No	_____
❑ Asthma	❑ Yes	❑ No	_____
❑ Bedwetting	❑ Yes	❑ No	_____
❑ Behavior Problems	❑ Yes	❑ No	_____
❑ Bleeding Disorder	❑ Yes	❑ No	_____
❑ Chronic Diarrhea	❑ Yes	❑ No	_____
❑ Constipation	❑ Yes	❑ No	_____
❑ Cystic Fibrosis	❑ Yes	❑ No	_____
❑ Depression	❑ Yes	❑ No	_____
❑ Diabetes	❑ Yes	❑ No	_____
❑ Ear Infections	❑ Yes	❑ No	_____
❑ Eating Disorder	❑ Yes	❑ No	_____
❑ Headaches	❑ Yes	❑ No	_____
❑ Hearing Loss	❑ Yes	❑ No	_____
❑ Heartburn	❑ Yes	❑ No	_____
❑ Heart Problems	❑ Yes	❑ No	_____
❑ Hepatitis	❑ Yes	❑ No	_____

CONDITION	ONGOING?		DATE BEGAN
❑ Hypertension	❑ Yes	❑ No	_____
❑ Kidney Failure	❑ Yes	❑ No	_____
❑ Pneumonia	❑ Yes	❑ No	_____
❑ Rheumatic Fever	❑ Yes	❑ No	_____
❑ Seizures	❑ Yes	❑ No	_____
❑ Skin Lesions	❑ Yes	❑ No	_____
❑ Sleeping Problems	❑ Yes	❑ No	_____
❑ Tuberculosis	❑ Yes	❑ No	_____
❑ Ulcerative Colitis	❑ Yes	❑ No	_____
❑ Undescended Testicle	❑ Yes	❑ No	_____
❑ Vision Problems	❑ Yes	❑ No	_____
❑ Warts	❑ Yes	❑ No	_____
❑ Other (list all):			

_____
_____
_____
_____
_____

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LIST ALL PREVIOUS SURGERIES AND HOSPITALIZATIONS: NONE

SURGERY/HOSPITALIZATION	PHYSICIAN/SURGEON	MONTH/YEAR

LISTCURRENT 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 ____