THE PHOENIX CHILDREN'S CENTER, LTD.
PATIENT HEALTH HISTORY FORM

Name of patient: _____ Sex: M / F Date of birth: ____/____/____

Name of person completing the form: _____ Relationship to patient: _____ Todays date ____/____/____

BIRTH HISTORY

Birth weight: _____ Weeks gestation: _____ Type of delivery: C-Section / Vaginal

Indication for C-section: _____ Birth complications: _____ Place of birth: _____

During the pregnancy did the mother: (If YES, please explain):

Have any medical problems?	YES	NO	_____
Smoke?	YES	NO	_____
Use any medications?	YES	NO	_____
Use alcohol or other drugs?	YES	NO	_____
Have problems with labor/delivery?	YES	NO	_____
Did the infant pass the new born hearing screen?	YES	NO	_____
Did the infant have a normal newborn blood screen?	YES	NO	_____

How long did the infant stay in the hospital after birth? _____

Was the infant admitted to the NICU? YES / NO If yes, length of stay: _____

PAST MEDICAL HISTORY

How is the child's general health? GOOD FAIR POOR EXPLANATION

Does the child have any allergies to medicines?	YES	NO	_____
Does the child have any allergies to environment, food, or insects?	YES	NO	_____
Is the child taking any medications?	YES	NO	_____

Please list any chronic health problems, serious illnesses or injuries: _____

Please list any hospitalizations (please include dates): _____

Please list any surgeries (including circumcision) (please include dates): _____

Has the child ever had any problems with the following? (if YES please explain) EXPLANATION

Growth / Development	YES	NO	_____
Past injuries	YES	NO	_____
Skin (disease / acne / eczema)	YES	NO	_____
Headaches	YES	NO	_____
Concussion	YES	NO	_____
Seizures	YES	NO	_____
Eyes / Vison	YES	NO	_____
Ears (infections/hearing)	YES	NO	_____
Nose (congestion/runny nose/injury)	YES	NO	_____
Throat (infections/large tonsils)	YES	NO	_____
Heart (disease/symptoms)	YES	NO	_____
Lungs (disease/wheezing/symptoms)	YES	NO	_____
Abdomen (pain/nausea/vomiting/diarrhea/constipation)	YES	NO	_____
Urine / Kidneys (disease/infections)	YES	NO	_____
Genital (infections/symptoms)	YES	NO	_____
Extremities/Feet	YES	NO	_____

FAMILY HISTORY

Family history unknown YES NO (if YES, please explain): _____

Have any of the child's blood relatives had the following? Please check the illness and family member as related to the child:

	Parent	Grandparent	Sibling	First Cousin	Uncle	Aunt
Allergies						
Anemia						
Asthma						
Cancer						
Celiac Disease						
Crohn's / UC						
Deafness						
Diabetes						
Drug Use						
Eczema						
Heart Disease						
Hyperlipidemia						
Hypertension						
IBD						
Kidney Disease						
Learning Disabilty						
Liver Disease						
Mental Illness						
Mental Retardation						
Migraines						
Seizures						
Thyroid Disease						

Development

Do you have any concerns about the following? (if YES, please explain) EXPLANATION

Developments	YES	NO	_____
Behaviors	YES	NO	_____
Eating Habits	YES	NO	_____
Sleeping Habits	YES	NO	_____
School Experience	YES	NO	_____
Bathroom / Toilet Habits	YES	NO	_____
Disciplines	YES	NO	_____
Other (please explain)	YES	NO	_____

Social History

Please list all household members living in the home including parents and siblings:

	Name	Date of birth	Occupation	Education
Father:				
Mother:				
Other:				
Other:				

Exposure / Habits:

Does any household members smoke? YES NO If Yes, where? Inside or Outside

Animal Exposure:

Are there pets in the home? Yes NO If yes, what type? _____

Infants / Toddlers:

Is your child in daycare? YES NO

School History:

Did / does your child attend school / preschool? YES NO

Current Grade: _____ Name of school: _____

Any concerns about relations with teachers? YES NO

Any concerns about relations with other students? YES NO

Have there been any recent major changes or stresses in the child's life? YES NO

If YES, please explain: _____