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

Name of Patient		Name of person completing form	
Date		Relationship to patient	
Sex Male Female	Race	Social Security Number	Date of Birth

Please list all people in household:

	NAME	DATE OF BIRTH	OCCUPATION	EDUCATION
Father				
Mother				
Other				
Other				
Other				

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

If YES, explain: _____

_____

Does the child go to a babysitter, pre-school or day care regularly? Yes No

BIRTH HISTORY

Birth Weight _____ Length _____ Place _____

During the pregnancy did the mother: (if YES, explain)			EXPLANATION
Have any medical problems?	YES	NO	
Smoke or drink?	YES	NO	
Use any medications?	YES	NO	
Use alcohol or other drugs?	YES	NO	
Have problems with labor/delivery?	YES	NO	

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

PAST MEDICAL HISTORY

Is the child's general health: GOOD FAIR POOR (check one)			EXPLANATION
Does the child have any allergies?	YES	NO	
Is the child taking any medications?	YES	NO	

Please list any hospitalizations, operations, serious illnesses or accidents with dates.

_____ Date _____

_____ Date _____

Has the child ever had any problems with the following? If YES, please explain.			EXPLANATION
EYES / VISION	YES	NO	
FEET	YES	NO	
DIGESTION / NUTRITION	YES	NO	
EARS / HEARING	YES	NO	
URINE / KIDNEYS	YES	NO	
JOINTS	YES	NO	
SKIN	YES	NO	
LUNGS	YES	NO	
TEETH	YES	NO	
HEART	YES	NO	
SEIZURES	YES	NO	
REPEATED INFECTIONS	YES	NO	

Have any of the child's blood relatives had the following diseases: (If YES, please list family member)

			FAMILY MEMBER
Heart Disease	YES	NO	
Tuberculosis	YES	NO	
High Blood Pressure	YES	NO	
Kidney Disease	YES	NO	
Allergies / Asthma	YES	NO	
Cancer	YES	NO	
Diabetes	YES	NO	
Mental / Emotional Problems	YES	NO	
Sickle Cell	YES	NO	
Seizures	YES	NO	

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 (Explain)	YES	NO	

IMMUNIZATIONS WILL BE COPIED ON IMMUNIZATION RECORD BY OFFICE STAFF

EXPOSURES / HABITS:

Do any household members smoke? YES NO

SCHOOL HISTORY:

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

Current grade_____ Name of School _____

Any concerns about school performance? _____

Any concerns about relations with Teachers YES NO

Students YES NO

This section is for TEENAGERS and is to be completed by the TEEN

Do you:

Use Tobacco?	YES	NO
Drink Beer or other Alcoholic Beverages?	YES	NO
Use any kind of Drugs?	YES	NO

(For Females) How old were you when you had your first period? _____

Are you sexually active?	YES	NO
If YES, do you use birth control?	YES	NO
Have you ever been pregnant or fathered a child?	YES	NO

Do you have any concerns about the following? (If YES, please explain.)

Safety Issues	YES	NO	
Substance Use (drugs, alcohol, tobacco)	YES	NO	
Sexually Transmitted Diseases	YES	NO	
Family Planning	YES	NO	
Other (explain)	YES	NO	

REVIEWED BY: _____ DATE: _____