PHOENIX CHILDREN'S *Medical Group*

Ph: (602) 933-3033 / Fax (602) 933-5245

New Patient Medical Information

Apply Patient Label

Referral (please check):

☐ Physician: _____ ☐ Web Site_____

☐ Emergency Department: _____ ☐ Other: _____

☐ Urgent Care: _____

When did the problem first start? _____

Since you first noticed it, is the problem ☐ Better? ☐ Worse? ☐ The Same?

PLEASE EXPLAIN ALL YES ANSWERS

Has this problem been treated previously? How? _____

☐ No ☐ Yes By Whom? _____

Is there a family history of this or a similar problem?

☐ No ☐ Yes By Whom? _____

Past Medical History:

Any major illnesses? ☐ No ☐ Yes _____

Previous operations: ☐ No ☐ Yes _____

Patient's Birth History:

For mother: # of pregnancies _____ # of children _____ # of this child _____

Birth weight _____ lbs _____ Oz # weeks gestation_____

Premature? ☐ No ☐ Yes Problems? ☐ No ☐ Yes _____

Breech position? ☐ No ☐ Yes Caesarian section? ☐ No ☐ Yes If yes, reasons_____

Social History: School:_____ Grade:_____

Developmental History: Child sat up at_____ Child walked at:_____ Child spoke at: _____

Review of Systems (any problems with):

Constitutional (Fever, unexplained weight loss, masses)	☐No	☐Yes*
Eyes (Blurred Vision)	☐No	☐Yes*
Ear, Nose, Throat	☐No	☐Yes*
Cardiovascular System (Chest pain, shortness of breath)	☐No	☐Yes*
Respiratory System (Asthma, Cough)	☐No	☐Yes*
Neurologic System (Numbness, Tingling in arms or legs)	☐No	☐Yes*
Gastrointestinal system (Abdominal Pain, Nausea)	☐No	☐Yes*
Genitourinary System (Menstrual Irregularity, Urinary)	☐No	☐Yes*
Hematologic/Lymphatic (Anemia, Blood Disorders, Immune System)	☐No	☐Yes*
Endocrine System (Diabetes, Thyroid)	☐No	☐Yes*
Psychiatric (Depression, Anxiety)	☐No	☐Yes*
Allergic/Immunologic (Eczema, Hives, Recurrent Infections)	☐No	☐Yes*
Musculoskeletal	☐No	☐Yes*

*If you marked yes above, please explain problem in more detail here:

_____ _____ _____

Signature & Printed Name of person completing this form | Date | Relationship to patient

_____ _____ _____

Practitioner Signature | Printed Name | Date & Time