PHOENIX CHILDREN'S *Medical Group*

Patient Questionnaire

Apply Patient Label

Patient History

Today's Date_____

Why is the patient seeing the provider today? _____

Any allergies including drugs? Yes No If yes, please list: _____

Taking any medication? Yes No If yes, please list: _____

_____

Lives at home with_____School/Grade_____

Past Medical History:

Birth History: Full term Yes No If premature, how many weeks: _____

Hospitalizations Yes No

If yes, please list why and dates: _____

_____

Prior surgeries Yes No

If yes, please list type of surgery and dates: _____

_____

Family History: (Patient's parents, siblings, and grandparents only)

Diabetes Yes No _____

Heart Disease Yes No _____

Hypertension Yes No _____

Kidney Problems Yes No _____

Bleeding Disorders Yes No _____

Anesthesia Problems Yes No _____

Additional Medical Information: _____

_____

_____

Occupation: _____ _____

Parent 1/Legally Authorized Representative Parent 2/Legally Authorized Representative

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Please check any problems (boxes) listed below which have significantly affected your child.

General		**Respiratory**		**Neurological**	
❑	Fevers	❑	Shortness of Breath	❑	Seizures
❑	Fatigue	❑	Wheezing	❑	VP Shunt
❑	Weight Loss	❑	Recent Upper Respiratory Infection	❑	Cerebral Palsy
❑	Weight Gain	❑	Chronic Lung Disease	❑	Leg Weakness
❑	Problems with Anesthesia	❑	Apnea	❑	Spina Bifida
ENT		❑	Asthma	**Musculoskeletal**	
❑	Frequent Ear Infections	**Allergic/Immunologic**		❑	Back Pain
❑	Frequent Colds	❑	Hives	❑	Muscle Weakness
❑	Nosebleeds	❑	Increased Susceptibility to Infection	❑	Muscular Dystrophy
❑	Snoring	❑	Seasonal Allergies	**Psychiatric**	
Dermatology		❑	Latex and/or Other Allergies	❑	Anxiety
❑	Rash	**Gastrointestinal**		❑	Depression
❑	Itching	❑	Nausea	❑	ADHD
❑	Eczema	❑	Vomiting	❑	Autism
Cardiovascular		❑	Constipation	❑	Autism Spectrum Disorder
❑	High Blood Pressure	❑	Stool Accidents	❑	Developmental Delay
❑	Heart Murmur	❑	Abdominal Pain	**Hematology/Lymphatic**	
❑	Chest Pain	**Genitourinary**		❑	Anemia
❑	Cyanosis	❑	Pain or Burning with Urination	❑	Easy Bleeding
❑	Congenital Heart Disease	❑	Blood in Urine	❑	Easy Bruising
Endocrine		❑	Urinary Frequency	❑	Cancer
❑	Excessive Thirst	❑	Urinary Urgency	❑	Sickle Cell Disease
❑	Excessive Urination	❑	Daytime Accidents with Urine	❑	Hemophilia
❑	Thyroid Disease	❑	Leaking of Urine	**Gynecology**	
❑	Growth Problems	❑	Bedwetting	❑	Started Menses at age _____ years
❑	Diabetes	❑	Difficulty Urinating	❑	Menstrual Problems
Genetics		❑	Urinary Tract Infections	❑	Ovarian Cysts
❑	Chromosome Abnormalities	❑	Abnormal Urine Stream	❑	Labial Adhesions
❑	Syndromes:_____	❑	Flank Pain		
❑	_____	❑	Kidney Stones		

Additional Medical Information: _____

_____

_____

_____ _____

Signature of Patient/Legally Authorized Representative — Relationship to Patient

_____ _____

Printed Name of Patient/Legally Authorized Representative — Date

_____ _____ _____

Practitioner Signature — Date — Time

_____

Practitioner Printed Name