PHOENIX CHILDREN'S Medical Group®

Patient Questionnaire

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: ____

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Occupation: Father______________________________ Mother____

PCH10930 (Rev. 3 (03/2016)

DOS:

PHOENIX CHILDREN'S Medical Group®

Patient Questionnaire

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: ____

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_______________________________________ ________________________

Signature of Patient/Legally Authorized Representative Relationship to Patient

_______________________________________ ________________________

Printed Name of Patient/Legally Authorized Representative Date & Time

_______________________________________ ________________________

Practitioner Signature Date & Time

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Practitioner Printed Name