

PEDIATRIC AND ADOLESCENT HISTORY

PT'S NAME _____

CHART# _____

Birth Date _____

Breast Fed? Yes No

Birth Weight _____

Formula Fed? Yes No

Type of Formula if special kind _____

Birth History

1 Was the pregnancy complicated? Yes No Explain _____

2 Was it a normal birth? Yes No Long labor? Yes No

3 Was your child born by Cesarean section? Yes No If yes, why? _____

4 Was your child kept in the hospital for any problems after birth? Yes No

If so, please explain the problem or check any below

- _____ Underweight (less than 5 lbs)
- _____ Premature - If so, how many months or weeks _____
- _____ Yellow skin (Jaundice) Was there an RH problem? _____
- _____ Lung or breathing problems
- _____ Heart problems
- _____ Infections
- _____ Meningitis
- _____ Spinal cord or spina bifida
- _____ Brain damage
- _____ Kidney damage
- _____ Too many fingers or toes
- _____ Clubbed feet or bone deformities
- _____ Eye problems
- _____ Poor sucking or feeding difficulties
- _____ Operations Kinds and dates _____ Other _____

5 Has your child ever had

- | | |
|--|---------------------------|
| _____ Measles | _____ Chicken Pox |
| _____ Mumps | _____ Pertussis |
| _____ Rubella (German Measles) | _____ Diphtheris |
| _____ Dental Problems | _____ High Blood Pressure |
| _____ Allergies to food If so, what kind(s)? _____ | |
| _____ Allergies to pollen If so, what kind(s)? _____ | |
| _____ Allergies to drugs If so, what kind(s)? _____ | |
| _____ Seizures, fits, convulsions If so, what kind(s)? _____ | |
| _____ Cause if known _____ | |

_____ Blood transfusions What for? _____ Date _____

- | | |
|---|--------------------------------|
| _____ Hernia | _____ Anemia |
| _____ Frequent Tonsillitis | _____ Tuberculosis |
| _____ Frequent headaches | _____ Asthma |
| _____ Frequent ear infections | _____ Cystic Fibrosis |
| _____ Frequent stomach pains | _____ Muscular Dystrophy |
| _____ Frequent diarrhea | _____ Polio |
| _____ Frequent vomiting | _____ Eye trouble, Ear trouble |
| _____ Frequent Urinary Tract infections or kidney disease | _____ Rheumatic Fever |
| _____ Frequent constipation | _____ Speech problem |
| _____ Operations Kinds and dates _____ | _____ Behavior problem |
| | _____ Suicide attempts |

_____ Accidents/Injuries Kinds and dates _____

6 Family History Do any illnesses run in the family? Please check If so, name person with illness (Mother, father, grandparent, sister, brother)

_____ Diabetes	_____ Heart Disease
_____ Kidney trouble	_____ Hypertension, High blood pressure
_____ Sinus infections or allergies	_____ Eczema
_____ Lung trouble/Tuberculosis	_____ Cancer- What type? _____
_____ Mental (Psychiatric)	_____ Glaucoma
_____ Hemophilia	_____ Sickle Cell disease
	Other _____

7 Immunization History Shots and dates given

NAME	DATES	REACTIONS
DP+/DT		
DPV		
MMR		
T B		

8 Social History

Years of Education _____ Currently in school _____ Drop out _____

Do you smoke? YES _____ NO _____ How much a day _____

Do you drink alcohol? YES _____ NO _____ How much a day _____

Do you take street drugs? YES _____ NO _____ What kind _____

Do you wear seat belts? YES _____ NO _____

Have you been exposed to AIDS? YES _____ NO _____

9 Gynecological and Obstetrical History

A MENSES

Age period began _____ An irregularity _____ Amount Slight _____ Medium _____ Heavy _____

Date of Last period _____ Days of flow _____ Painful Periods _____

10 Hospitalization, What for?

Date

CONSENT

I do consent to treatment rendered by the Medical Providers and counseling services of the Sun Life Family Health Center, Inc

PATIENT'S NAME _____

DATE _____

SIGNATURE _____

PATIENT

WITNESS _____

PARENT

Sun Life Family Health Center
VFC Immunization Screening

Child's name _____ Date of birth _____

- Don't Please answer these questions by checking the boxes
Yes No know If any Yes answer please elaborate with space given
- Is your child sick with something more serious than a minor illness?
- Ever had a reaction after immunizations?
- Have a history of seizures?
- Allergy to Neomycin or streptomycin?
- Anyone in household Aids/cancer tx/Leukemia/steroid/organ transplant/immune suppressed?
- Living with someone who has never had polio vaccine?
- Pregnant or plan to be in the next three months?
- Received IGG or blood by-products in the last 6 months?
- Serious allergic reaction to eggs, yeast, or gelatin?

VFC ELIGIBILITY Age 0-18 and is (check only one box)

- A) Is enrolled in KidsCare
B) Enrolled in AHCCCS
C) Does not have health insurance
D) Is American Indian or Alaskan Native
E) Has health insurance that does not pay for vaccines

Check here if this child has health insurance that pays for vaccine
These children do not qualify for VFC

Please be advised, if your insurance company does not cover immunizations and you do not let us know at the time of visit, it is your responsibility to pay the cost involved We cannot make VFC retroactive and you are only eligible for VFC at the time of the visit If you are unsure if immunizations and well check-ups are covered, please contact your insurance company

ASIIS Arizona State Immunization Information System

"I agree to allow the health care provider giving vaccinations to release information about all vaccinations given to me, or to the person for whom I am authorized to consent, to the ASIIS, other health care providers and schools in order to avoid receiving unnecessary vaccinations and to provide information about what immunizations have been received I understand that I am not required to agree to the release of this information in order to receive the vaccinations I request "

Signature _____ Date _____

Where have past immunizations been given? _____