PHOENIX CHILDREN'S Medical Group®

Initial History Questionnaire

Why is the patient seeing the provider today? ____________________

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

Systemic		Eyes		Psychiatric	
☐	Weight Loss	☐	Vision Loss	☐	Mood Changes
☐	Weight Gain	☐	Floaters	☐	Anxiety
☐	Unexplained Fevers	☐	Sun Sensitivity	☐	Depressed
☐	Night Sweats	**Respiratory**		**Genitourinary**	
☐	Chills	☐	Cough	☐	Pain During Urination
Dermatology		☐	Mucous Production	☐	Irregular Menstrual Cycles
☐	Dry Skin	☐	Shortness of Breath	☐	Vaginal Discharge
☐	Rash	**Cardiovascular**		☐	Penile Discharge
☐	Itching	☐	Chest Pain	**Musculoskeletal**	
☐	Blisters	☐	Palpitations	☐	Joint Pain
☐	Photosensitivity	**Gastrointestinal**		☐	Muscle Aches
☐	Easy Bruisability	☐	Constipation	☐	Swollen Joints
☐	Flushing	☐	Diarrhea	**Endocrine**	
☐	Hair Loss	☐	Abdominal Pain	☐	Thyroid Disease
ENT		☐	Blood in Stool	☐	Diabetes Mellitus
☐	Hearing Loss	**Neurological**		☐	Extra Hair Growth
☐	Nasal Congestion	☐	Headache	**Hematologic/Lymphatic**	
☐	Sore Throat	☐	Seizures	☐	Swollen Glands in Neck
☐	Nasal Discharge			☐	Bone Pain
				Allergy/Immunologic	
				☐	Seasonal Allergies/Hay Fever
				☐	Runny Nose (Rhinorrhea)

Past Medical History

Do you think your child is in good health? ☐ Yes ☐ No Please Explain: ____________________

Does your child have any serious illness or medical problems? ☐ Yes ☐ No If so, please describe: ____________________

Has your child had serious injuries or accidents? ☐ Yes ☐ No If so, describe the injuries: ____________________

Has your child had any surgery? ☐ Yes ☐ No If so, please explain: ____________________

Has your child ever been in the hospital? ☐ Yes ☐ No If so, please explain: ____________________

Is your child allergic to any medications or drugs? ☐ Yes ☐ No If yes, please list: ____________________

Has the patient ever had any of the following? (Please check all that apply)

	Yes	*No*		*Yes*	*No*		*Yes*	*No*
ADD/ADHD			Hepatic Disorder			Genetic Conditions		
Cystic Fibrosis			Muscular Dystrophy			High Blood Pressure		
Hematology Disorder			Blindness/Deafness			Psychiatric Disorder		
Bleeding Disorder			Birth Defects			Heart Disease		
Learning Disabilities			Endocrine Disorder			Growth/Bone Disorder		
Seizure Disorder			High Cholesterol			Intellectual Disabilities		
Asthma			Developmental Delays/Autism			Renal Disease		
Diabetes Mellitus			Neurological Disorders					

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PHOENIX CHILDREN'S Medical Group®

Initial History Questionnaire

Birth History

Birth weight:____________________

Was the baby born at: ☐ Full term ☐ Early ☐ Late

If early, at how many weeks was the baby born? ________

Did the mother have any illness or problem with her pregnancy?
☐ Yes ☐ No Please explain:________________

During the pregnancy, did the mother: (Check all that apply)

☐ Smoke ☐ Drink Alcohol ☐ Use drugs or medications

If so, What: __________ When: ________

Was the delivery ☐ Vaginal ☐ Cesarean

If cesarean, why?____________________

Did the baby have any problems right after birth?

☐ Yes ☐ No Explain:________________

Was early feeding: ☐ Breast ☐ Bottle

Did the baby go home with the mother from the hospital?

☐ Yes ☐ No Explain: ________________

Family History: Have any family members had any of the following? (check all that apply)

			Who	Comments
Asthma	☐ Yes	☐ No		
Birth Defects	☐ Yes	☐ No		
Coronary Artery Disease < 50	☐ Yes	☐ No		
Cancer	☐ Yes	☐ No		
Congenital Heart Disease	☐ Yes	☐ No		
Cystic Fibrosis	☐ Yes	☐ No		
Diabetes Mellitus	☐ Yes	☐ No		
Endocrine Disorder	☐ Yes	☐ No		
Gastrointestinal Disorder	☐ Yes	☐ No		
Genetic Conditions	☐ Yes	☐ No		
Hematologic Disorder	☐ Yes	☐ No		
Hepatic Disorder	☐ Yes	☐ No		
High Cholesterol	☐ Yes	☐ No		
High Blood Pressure	☐ Yes	☐ No		
Learning Disabilities	☐ Yes	☐ No		
Intellectual Disabilities	☐ Yes	☐ No		
Muscular Dystrophy	☐ Yes	☐ No		
Obesity	☐ Yes	☐ No		
Developmental Delays/Autism	☐ Yes	☐ No		
Psychiatric Disorder	☐ Yes	☐ No		
Renal Disease	☐ Yes	☐ No		
Seizure Disorder	☐ Yes	☐ No		
Sickle Cell Abnormality	☐ Yes	☐ No		
Sudden Death< age 50	☐ Yes	☐ No		
Down Syndrome (Trisomy 21)	☐ Yes	☐ No		

*Additional Family History:*____________________

Social History: Please list all those living in the child's home.

Name	Relationship to Child	Health Problems

PHOENIX CHILDREN'S *Medical Group* ®

Initial History Questionnaire

Are there siblings not listed? If so, please list their names and ages.____

____

If mother and father are not living together or if child does not live with parents, what is the child's custody status?

____

If one or both parents are not living in the home, how often does the child see the parent or parents not in the home?

____

Does your child attend school? ☐ Yes ☐ No If yes, what grade? ____________

If no, does your child attend daycare or have a home sitter? ____________

Are there any pets in the home? ☐ Yes ☐ No If so, what kind ____________________________________

____ ____________

Signature of Patient/Legally Authorized Representative Date

____ ________________________

Printed Name of Patient/Legally Authorized Representative Relationship to Patient

____ ________________________

Practitioner Signature Date Time

____

Practitioner Printed Name

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Authorization to Use and/or Disclose Protected Health Information for Publication and Educational Purposes

I authorize Phoenix Children's Hospital to use and/or disclose (share) the protected health information about me or my child (or person for whom I am the legally authorized representative) as described below. I understand that Phoenix Children's Hospital is a teaching institution that trains people who work in health care, both inside and outside the organization. I have the right to decide if I want my protected health information, which may include certain medical record information, photographs, videos, images or other recordings, to be shared with people outside of Phoenix Children's Hospital, such as a medical/academic institution, professional association or publication.

1. Who may use/disclose the information?

☐ Phoenix Children's Hospital workforce members for educational, medical, scientific, and/or teaching purposes at Phoenix Children's Hospital, other medical/academic institutions, and/or local, national and international conferences

☐ Phoenix Children's Hospital workforce members for publication purposes, including journals, textbooks, case studies and electronic publications

2. Description of information that may be used/disclosed:

☐ Still photography

☐ Videotaping (including audio)

☐ Digital imaging in hard copy, electronic media or both

☐ Patient age, description of condition or injuries, diagnosis, treatment

☐ Other: ______________________________

3. Who may receive the information?

☐ People participating in a medical/academic educational/training session

☐ People reading a medical/academic journal, textbook, or educational article

☐ Other: ______________________________

4. The information will be used/disclosed for the following purposes:

☐ Medical/academic education

☐ Publication in medical textbooks, journals, articles or electronic publications

Authorization to Use and/or Disclose Protected Health Information for Publication and Educational Purposes

5. I understand that the image may be seen by members of the general public, in addition to scientists and medical professionals that regularly use these publications in their professional education. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me. I also agree for my image to be shown for teaching/educational purposes and to be used for my medical record. I understand that I will not receive payment from any party.

6. I understand that once my protected health information is disclosed to third parties under this authorization, Phoenix Children's Hospital cannot guarantee that the third parties will not redisclose the protected health information. The third party may not be required to abide by this authorization, or applicable federal and Arizona law governing the use and disclosure of my protected health information.

7. I understand that I may refuse to sign this authorization form and that my refusal to sign will not affect my ability to obtain treatment or payment or my enrollment or eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.

8. I understand that I may change my mind and revoke this authorization at any time by notifying, in writing, the Phoenix Children's Hospital's Health Information Management Department at 1919 East Thomas Road, Phoenix, AZ 85016. The revocation will take effect when Phoenix Children's Hospital receives it, except to the extent that Phoenix Children's Hospital or others have already relied on it.

9. Unless otherwise revoked, I understand that this authorization has no expiration date.

I represent that I have full legal authority to sign this authorization. I have read and understand the terms of this authorization and I have had a chance to ask questions about the use and disclosure of my protected health information. I authorize Phoenix Children's Hospital to use or disclose my protected health information in the manner described above. I understand that I may request a copy of this authorization after I have signed it. I understand the matters discussed on this form. I release, waive and discharge Phoenix Children's Hospital from any and all claims and liabilities that may result from the lawful use or disclose of the above information to the extent indicated and authorized herein.

______________________________ ______________________________

Signature of Patient or Legally Authorized Representative | Date & Time

______________________________ ______________________________

Printed Name of Patient or Legally Authorized Representative | Relationship to Patient