PEDIATRIC AND ADOLESCENT HISTORY

PT'S NAME _____

CHART# _____

Birth Date _____
Birth Weight _____

Breast Fed? Yes No
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 Ceasarean 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 bifada
_____ 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
_____ Mumps
_____ Rubella (German Measles)
_____ Dental Problems
_____ 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
_____ Frequent Tonsillitis
_____ Frequent headaches
_____ Frequent ear infections
_____ Frequent stomache pains
_____ Frequent diarrhea
_____ Frequent vomiting
_____ Frequent Urinary Tract infections or kidney disease
_____ Frequent constipation
_____ Operations Kinds and dates
_____
_____
_____ Accidents/Injuries Kinds and dates
_____
_____

_____ Chicken Pox
_____ Pertussis
_____ Diptheris
_____ High Blood Pressure
_____ Anemia
_____ Tuberculosis
_____ Asthma
_____ Cyotic Fibrosis
_____ Muscular Dystrophy
_____ Polio
_____ Eye trouble, Ear trouble
_____ Rheumatic Fever
_____ Speech problem
_____ Behavior problem
_____ Suicide attempts

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

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

Yes	No	Don't know	Please answer these questions by checking the boxes 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? _____

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