PHOENIX CHILDREN'S Medical Group

PATIENT HISTORY
REVIEW OF SYSTEMS

Apply Patient Label

FILL OUT THESE FORMS BEFORE YOUR APPOINTMENT

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

Constitutional
- ❑ Recent weight gain_____(amount)
- ❑ Recent weight loss_____(amount)
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever

Eyes
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness
- ❑ Feels like something in eye
- ❑ Itching eyes

Ears–Nose–Mouth–Throat
- ❑ Loss of hearing
- ❑ Nosebleeds
- ❑ Loss of smell
- ❑ Dryness in nose
- ❑ Runny nose
- ❑ Bleeding gums
- ❑ Sores in mouth
- ❑ Dryness of mouth
- ❑ Hoarseness
- ❑ Difficulty in swallowing

Cardiovascular
- ❑ Pain in chest
- ❑ High blood pressure

Respiratory
- ❑ Shortness of breath
- ❑ Cough
- ❑ Coughing of blood
- ❑ Wheezing (asthma)

Gastrointestinal
- ❑ Nausea
- ❑ Vomiting
- ❑ Stomach pain
- ❑ Constipation
- ❑ Diarrhea
- ❑ Blood in stools
- ❑ Heartburn

Genitourinary
- ❑ Pain or burning on urination
- ❑ Blood in urine
- ❑ Sores on private parts

For Women Only:

Periods regular? ❑ Yes ❑ No

Date of last period? ___/____/_____

Integumentary (skin)
- ❑ Easy bruising
- ❑ Rash_____
- ❑ Sun sensitive (sun allergy)
- ❑ Tightness
- ❑ Hair loss
- ❑ Color changes of hands or feet in the cold

Neurological System
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting
- ❑ Numbness or tingling of hands
- ❑ Numbness or tingling of feet
- ❑ Memory loss
- ❑ Night sweats

Allergic/Immunologic
- ❑ Frequent sneezing
- ❑ Hives

Hematologic/Lymphatic
- ❑ Swollen glands

Psychiatric
- ❑ Anxiety
- ❑ Easily losing temper
- ❑ Depression
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep

Endocrine
- ❑ Excessive thirst
- ❑ Excessive urination

Musculoskeletal
- ❑ Morning stiffness, lasting how long?
  _____Minutes_____Hours
- ❑ Muscle weakness
- ❑ Muscle tenderness
- ❑ Back pain
- ❑ Joint pain
- ❑ Joint swelling

List joints affected in the last 6 months

_____

_____

_____

_____

_____

_____

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PAST MEDICAL HISTORY

Does your child have or ever had? Check if "yes"

☐ Cancer	☐ Heart problems	☐ Anxiety
☐ Fibromyalgia	☐ Diabetes	☐ Tuberculosis
☐ Stomach ulcers	☐ Epilepsy/Seizures	☐ Rheumatic Fever
☐ Kidney disease	☐ Valley Fever	☐ Psoriasis
☐ Crohn's disease	☐ Immunodeficiency	☐ High Blood Pressure
☐ Ulcerative Colitis	☐ Depression	☐ Asthma

☐ Other significant illness (please list) _____

SOCIAL HISTORY

Who lives at home with patient? _____

Patient use: tobacco? ☐ Yes ☐ No Alcohol? ☐ Yes ☐ No

Do you use drugs for reasons that are not medical? ☐ Yes ☐ No

If yes, please list _____

Do you exercise regularly? ☐ Yes ☐ No Hours per week: _____

Type of exercise:

Grade in school _____ Grades _____

# of days absent from school due to rheumatic disease?_____

TRAVEL in last year: _____

PETS: _____

IMMUNIZATIONS:

☐ Up-to-date

☐ Date of last immunization _____

☐ Chickenpox _____

☐ Varicella (chickenpox) vaccine

Previous Operations

Type & Year	*Type & Year*
1.	3.
2.	4.

FAMILY HISTORY:

	IF LIVING		IF DECEASED	
	Age	Medical Problems	Age at Death	Cause
Father				
Mother				

Number of sisters _____ Number of brothers _____ Number deceased _____

Medical problems of brothers and sisters: _____

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PATIENT HISTORY: REVIEW OF SYSTEMS

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FAMILY HISTORY:

Do you know of any blood relative who has or had: (check and give relationship)

- ❑ Psoriasis _____
- ❑ Lupus_____
- ❑ Fever Syndrome_____
- ❑ Ankylosing Spondylitis_____
- ❑ Rheumatoid arthritis_____
- ❑ Childhood arthritis _____
- ❑ Gout _____
- ❑ Rheumatic fever _____
- ❑ Crohn's Disease/Ulcerative Colitis_____
- ❑ Fibromyalgia_____
- ❑ Immune Deficiency Syndrome _____
- ❑ Heart Disease _____
- ❑ High Blood Pressure _____
- ❑ Stroke _____
- ❑ Thyroid Disease _____
- ❑ Epilepsy/Seizures _____
- ❑ Asthma _____
- ❑ Diabetes_____
- ❑ Cancer _____

_____ _____
Signature of Patient/Legally Authorized Representative Date

_____ _____
Printed Name/Patient or Legally Authorized Representative Relationship to Patient

_____ _____ _____
Practitioner Signature Date Time

_____
Practitioner Printed Name