



Scottsdale Children's Group

PATIENT HISTORY

Name: _____

DOB: _____

Allergies: _____

Date first seen: _____

NAME	DATE OF BIRTH	HEALTH STATUS	OCCUPATION
Mother			
Father			
Sibling			
Sibling			
Sibling			

FAMILY HISTORY

Allergy..... Y N Asthma..... Y N Bone / Joint..... Y N
 Cardiac..... Y N Endo / Joint..... Y N Genetic..... Y N
 Hematologic..... Y N Neurologic..... Y N Urinary..... Y N
 Childhood deaths..... Y N Other _____

MEDICAL HISTORY

Medical History: _____

Surgery History (Include age & type of surgery): _____

Hospitalizations (Include age, diagnosis & length of hospitalization): _____

SOCIAL HISTORY

Who does the patient live with: _____
 Does the patient divide time between 2 or more households? _____
 If parents are divorced, what is the custody status? _____
 List all types of pets: _____

BIRTH HISTORY (for patients 0-2 months only)

Name of Obstetrician _____
 How many total pregnancies? _____ • How many live children? _____
 Any difficulties during this pregnancy? Yes No _____
 Any medications taken during this pregnancy? Yes No _____
 Any abnormal lab or ultrasound results? Yes No _____
 Any street drugs or alcohol use during this pregnancy? Yes No _____
 Any medical or mental health issues during this pregnancy? Yes No _____

Name of hospital: _____ Vaginal or C-Section delivery? _____
 Any complications of labor or delivery? Yes No _____
 Birth Weight _____ lbs _____ oz How long did your baby stay in the hospital? _____
 Did he/she have any medical problems? Yes No _____