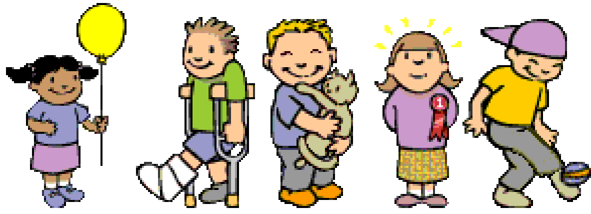
Sonoran Medical: Pediatric Patient Health History



Today's Date: ____________________

Name:___________________________
Date of Birth:____________________
Birth Weight:_____________________
Race: ___________________________
Ethnicity: _______________________
Preferred Language: ______________

Type of Delivery:
□Vaginal □Cesarean Section

Any complications during delivery or pregnancy? Describe

____

____

Drug Allergies (include reaction):

____

____

Current Medications and Dosage:

____

____

Past/Current Medical Problems:

____

____

Past Surgeries:

____

____

Pharmacy Name: _________________
Pharmacy Number: (___)____________
Cross Streets:____________________

Social History:

Who do you live with?

____

What grade are you in school? ______
Smokers at home? □YES □NO
Do you have pets? □YES □NO
What Type? ______________________
Blood Transfusions? □YES □NO

Immunizations (month/year)

□DTP or DTaP:___________________
□Hep B:_________________________
□Hib:___________________________
□IPV (polio):_____________________
□Hep A:_________________________
□MMR:__________________________
□Varicella:_______________________
□Prevnar:________________________
□Flu Shot:_______________________

Have you ever had any of the following? Dates:

□Chicken Pox __________________
□Asthma ___________________
□Seizure ___________________
□Heart Problems ________________
□Concussion ___________________

List any problems in your blood relatives and their relationship to you.

Heart:__________________________
Diabetes:_______________________
High Blood Pressure:______________
High Cholesterol:_________________
Seizures:_______________________
Breast Cancer:___________________
Colon Cancer:___________________
Lung Cancer:____________________
Depression:_____________________
Sudden Death:___________________

Provider_____ MA______ Front______ Date _________

Sonoran Medical Centers

Patient Medication, Vitamin and Supplement Log

for (name) ______________________________ DOB: ______________ Today's Date: ______________

Include prescription medications, over-the-counter medications, vitamins and herbal supplements

Pharmacy Name: ______________________________ Phone: ______________________ Pharmacy Cross Streets: ______________________________

Mail Order Pharmacy Name: ______________________________ Mail Order ID #: ______________________________

Start Date	Name of Medicine Brand Name/Generic Name	Dose (mg, units)	# taken per day	When do you take it? Morning/night, after meals	With food? Y or N	What's it for? Purpose	Size/color/ shape	Prescribed by Provider's name	Local Pharm or Mail order	Important Comments (danger signs, side effects, interactions)

Please bring this updated form with you to all of your medical office visits. If your medicines change, please tell your medical provider.
Check the detailed drug sheets provided by the pharmacy with each medication, or talk to your doctor about possible side effects, danger signs and interactions.

Allergies to: ____

Other Medical Providers that you are seeing (please include dentist and eye doctor):

Last Seen	Provider name	Specialty	Problem they are treating	Comments

SONORAN
MEDICAL CENTERS

Sonoran Medical Centers
19875 N. 51st Avenue
Glendale, AZ 85308
Phone: (623) 581-8998
Fax: (623) 581-6461

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Name: ____ **Date of Birth:** _______________
Phone:_____________________ **Address:** ____
City:__________________________ **State:**_______________ **Zip Code:** ___________________________

I hereby authorize
Name of facility:____
Address:____ **City:**________________________
State:_________ **Zip Code:**_______________ **Phone:**___________________ **Fax:**_____________________
to disclose the following Protected Health Information pertaining to the patient listed above to Sonoran Medical Centers.

Options below must be completed in order to release records.

For the Following Purpose:

☐ New Primary Care Physician
☐ Personal Records
☐ Consultation with Specialist
☐ Insurance Company
☐ Other (Specify) __________________
☐ Other (Specify) ______________________

Information to be Released:

☐ All Records
☐ Records from __________ to__________
☐ Office Note
☐ Radiology Report ☐ Lab result
☐ Billing Statements

I understand this authorization covers records relating to communicable diseases, acquired immunodeficiency syndrome ("AIDS'), human immunodeficiency virus ('HIV"), behavioral and/or mental health care, alcohol and/or drug abuse treatment, and genetic testing, if any such records exist.
I understand that Sonoran Medical Centers will not condition treatment on whether I sign this Authorization.
I understand that I have the right to revoke this authorization at any time except to the extent that the above-named facility has already taken action in reliance on it. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to the mailing address listed above. I understand the revocation will not apply to information that has already been released in response to this Authorization.
I understand that, if this information is disclosed to a third party, the information may no longer be protected by federal privacy regulations and may be redisclosed by the person or entity that receives this information.

I understand that this authorization will expire one (1) year from date of signing unless specified below.

Desired Expiration Date ____________________

__________________________________ __________________________________
Signature **Date**

__________________________________ __________________________________
Print Name **Relationship to Patient (if not patient)**

Consent for Treatment of a Minor

I give permission for my child, _________________________, date of birth ________________ to be medically evaluated and treated at Sonoran Medical Centers. I understand that it may be necessary to perform diagnostic tests (for example, a throat culture or blood test) in the course of the evaluation. I accept responsibility for provider charges and laboratory fees.

This consent applies to:
1. Complete provider check-up (including blood and urine samples)
2. Hearing, vision, and blood pressure screening
3. First aid and emergency care
4. Prescription and treatment for illness
5. Referrals to an outside agency (for example: hospital, radiology) for services not provided at the office

This consent does not apply to:
1. Immunizations/injections – in addition to this form, parental/legal guardian consent for specific injection would still be needed prior to injection)
2. Any surgical procedure – parent or legal guardian would need to be present.

Mark **ONE** of these selections:

___ **With Parent/ Legal Guardian Present** – restricted to medical care when parent or guardian is in office (Excludes emergency care and items required under Arizona/Federal laws)

Names of Parent(s)/Legal Guardian(s)____

___ **Without Parent/Legal Guardian Present**
I give permission for my child to be medically evaluated and treated at Sonoran Medical Centers in my absence. My child will be accompanied by:
[ ] himself/ herself
[ ] babysitter (name) ____________________
[ ] other (name, relationship) ________________________________

I give permission for the provider to share any relevant health information with the person listed above who is accompanying my child.
If there are any services that you do not consent to in your absence, please list:

____

This consent will remain in effect until the patient's 18th birthday, until amended, or until revoked in writing (whichever is earlier).

________________________________	________________________________
Child's name	*Today's Date*
________________________________	________________________________
Parent or Legal Guardian Signature	*Parent or Legal Guardian Name*