SONORAN MEDICAL: TEEN PATIENT HEALTH HISTORY

Today's Date: _____

Name:_____
Name you prefer to be called: _____
Date of Birth:_____
Race: _____
Ethnicity:_____
Preferred Language:_____

Current Medications:
(include strength and how often taken)

1. _____
2. _____
3. _____
4. _____

Pharmacy Name: _____
Pharmacy Phone: (____)_____
Pharmacy Cross Streets: _____
Allergies to Medications: (include effect)

1. _____
2. _____
3. _____
4. _____

List Past Surgeries: (include year of surgery)

1. _____
2. _____
3. _____
4. _____

List Past/Chronic Medical Problems:

1. _____
2. _____
3. _____

Have you ever had any of the following? (date)
Chicken Pox _____
Asthma_____
Seizure_____
Heart Problems_____
Concussion_____
Females:
What age did you start your period? _____
How many pregnancies?_____
Live Births_____ Miscarriages_____
Abortions_____

Social History:
Who do you live with? _____
What year are you in school? _____
Smokers at home? _____
Do you have pets? _____
What Type? _____
Do you currently smoke? YES NO
How much? _____ per day
Did you ever smoke? YES NO
How much? _____ per day
What year did you quit? _____
How long did you smoke? _____
Do you drink alcohol? _____
How much alcohol do you drink? _____
Any Illegal Drug use_____
Any IV Drug Abuse _____
Any Tattoos _____
Any Blood Transfusions _____

Immunizations (month/year)
DTP or DTaP:_____
Hep B:_____
Hib:_____
IPV (polio):_____
Hep A:_____
MMR:_____
Varicella:_____
Prevnar:_____
Flu Shot:_____
HPV (3 shots):_____
Meningitis: _____

Family History: Blood Relatives AND Relationship

Heart Disease _____
Diabetes _____
Strokes _____
High Blood Pressure _____
Depression _____
Thyroid Disease _____
Colon Cancer _____
Lung Cancer _____
Prostate Cancer _____
Breast Cancer _____
Ovarian Cancer _____
Uterine Cancer _____
Other _____

If you are a patient of Dr. Arlene England, please complete Gyn Patient Health History also**.**

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
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)**

SONORAN
MEDICAL CENTERS

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*