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 done)

1. ____________________________________
2. ____________________________________
3. ____________________________________
4. ____________________________________

List Past/Chronic Medical Problems:

1. ____________________________________
2. ____________________________________
3. ____________________________________

Have you ever had any of the following? (Dates)
Chicken Pox _______________________________
Asthma ___________________________________
Seizure ___________________________________
Heart Problems _____________________________
Concussion ________________________________

Please provide a copy of your immunization records

Family History: (blood relatives only)	**Was cause of death?**	**Relationship to you?**
Heart Disease		
Cancer Breast		
Cancer Colon		
Cancer of Lung		
Cancer of Ovaries		
Cancer of Prostate		
Cancer of Uterus		
Stroke		
Depression		
Diabetes		
High Cholesterol or Triglycerides		
High Blood Pressure		
Thyroid Disease		
Other		

Social History:
Who do you live with? _______________________
What year are you in school? __________________
Any tobacco users at home? __________________
Do you have pets? _________________________
What Type? ______________________________
Females:
What age did you start your period? __________
How many pregnancies? ____________
Live Births: __________ Miscarriages: __________
Abortions: __________

	How much?	**How often? (day/wk/mo)**	**Age Start - Stop**
Cigarette?			-
Cigarette- If restarted			-
Cigar?			-
Chew?			-
Pipe?			-
Vape?			-
Marijuana?			-
Alcohol? Type:			-
Caffeine?			-
Illegal Drugs?			-
Other?			-

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
☐ FMLA/Disability
☐ Other (Specify) ___________________
☐ Other (Specify) _______________________

Information to be Released:
☐ All Records
☐ Records from ___________ to___________
☐ Office Note
☐ Radiology Report ☐ Lab result
☐ Other
☐ Billing Statements
☐ FMLA/Disability Forms (please mark above if records to be released also)

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. Immunizations (in addition to this form, parental/guardian consent for specific immunization would still be needed prior to injection)
4. First aid and emergency care
5. Prescription and treatment for illness
6. Referrals to an outside agency (for example: hospital, radiology) for services not provided at the office

Mark **ONE** of these selections:

___ **With Parent/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)/Guardian(s)____

___ **Without Parent/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 Guardian Signature *Parent or Guardian Name*