



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: _____

Pprevnar: _____

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. Jacqueline Belen, please complete Gyn Patient Health History also.

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