Yossio Pediatrics, PLLC

Pediatric Health History

Ages 0-12 years

Child's name: ____________________ (First) ____________________ (Middle Initial) ____________________ (Last)

Sex: ❑ Male ❑ Female Date of birth ____/____/____

Parent/Guardian: ____________________ (First) ____________________ (Middle Initial) ____________________ (Last)

Phone: ____________________

Birthplace

Hospital: ____________________

City ____________________ State: ____________________

Prenatal

Did you receive prenatal care? ❑ No ❑ Yes

What month of pregnancy did you start your prenatal care? ____________________

Who did you see for prenatal care? ____________________

Who delivered your baby? ____________________

Did you attend prenatal classes? ❑ No ❑ Yes

Mother's Health During Pregnancy

Please indicate any of the following that were problems for you during your pregnancy.

❑ Vaginal bleeding ❑ Headaches

❑ Weight ❑ High blood pressure

❑ Swelling of the feet or ankles ❑ Gestational diabetes

❑ Other: ____________________

Did you consume alcohol during your pregnancy? ❑ No ❑ Yes, amount __________ frequency __________

Did you smoke during your pregnancy ❑ No ❑ Yes, amount ____________________

Did you take any prescription or over-the-counter drugs during your pregnancy? ❑ No ❑ Yes

Did you use any illegal drugs during your pregnancy? ❑ No ❑ Yes

Labor/Delivery

Gestational age at time of delivery? __________ weeks

Was your labor induced? ❑ No ❑ Yes How long were you in labor for? __________

Type of birth: ❑ Vaginal ❑ C-section Were forceps used? ❑ No ❑ Yes

Baby's weight at birth: __________ Length: __________ Apgar (if known): __________

Any complications at birth? ❑ No ❑ Yes, explain: ____________________

Please indicate any of the following complications that your baby had after delivery.

❑ Seizure ❑ Jaundice ❑ Infection ❑ Vomiting

❑ Congenital abnormalities ❑ Difficulty breathing ❑ Difficulty sucking ❑ Cyanosis

❑ Other: ____________________

How long did the baby stay in the hospital after delivery? ____________________

Did the baby have to be in a special nursery? ❑ No ❑ Yes

Was the baby circumcised? ❑ No ❑ Yes ❑ N/A Physician: ____________________

Child's History

List any medical problems your child currently has and when they started:

If your child is being treated for any illness or medical problems by another health care provider, describe the problem and indicate who is treating your child:

Has your child had any surgeries/procedures or been hospitalized? ❑ No ❑ Yes, please list below:

Hospital	Reason	Date	Physician

Immunizations

	Date	Date	Date	Date
DTP				
MMR				
OPV				
HIB				

Nutrition:

Please indicate the type of feeding your child receives/received.

❑ Breast Frequency: ______ Duration: ______

❑ Bottle Frequency: ______ Amount: ______ ounces Type of formula: ______

Does your child currently take vitamins: ❑ No ❑ Yes, name and dose: ______

Is your child on solid foods: ❑ No ❑ Yes

Age when cereal started: ______ Age when vegetable started: ______

Age when juices started: ______ Age when meats started: ______

Age when fruits started: ______ Age when eggs started: ______

Please indicate any of the following that your child currently has or has had in the past.

❑ Crossed or wandering eyes
❑ Recurring ear infection
❑ Ear tubes
❑ Speech problems
❑ Hearing loss
❑ Frequent colds
❑ Genetic disorders
❑ Asthma
❑ Hay fever
❑ Pneumonia
❑ Heart murmur
❑ Anemia
❑ Chronic/frequent diarrhea
❑ Recurrent vomiting
❑ Bed wetting
❑ Scoliosis
❑ Pain in arms, legs, joints
❑ Swelling in arms, legs, joints
❑ Headaches
❑ Seizures
❑ Whooping cough
❑ Chicken pox
❑ Measles
❑ Rubella (3 day measles)
❑ Mumps
❑ Polio
❑ Kawasaki's disease
❑ Scarlet fever
❑ Colic
❑ Jaundice
❑ Rheumatic fever
❑ Other, please list: ______

Does your child have any of the following allergies:
- ❑ No allergies ______
- ❑ Medications, list: ______
- ❑ Food, list: ______
- ❑ Other, list: ______

Development 0-5 years of age

Current age of your child:

How old was your child when he/she started doing the following?

Rolled over by self ______ Stood alone ______ Caught a ball ______
Sat by self ______ Walked by self ______ Talking ______
Crawled ______ Fed self ______ Toilet trained ______

If the section below does not apply to your child at this time, skip to the next section. If this section does apply to your child, please indicate the date on the line below the date that you are completing this information.

Development 6-18 years of age

Date this section is being completed: ______

Current age of your child: ______

How old was your child when he/she started school? ______ years

What grade is your child in? ______ grade

Does your child have any hearing problems? ❑ No ❑ Yes

Does your child have any vision (eye) problems? ❑ No ❑ Yes

How does your child learn best? ❑ Written materials ❑ Audio (listening) ❑ Visual (pictures)

Does your child have any learning disabilities? ❑ No ❑ Yes, explain: ______

Social History

Does your child have any kind of problems relating to his/her peers? ❑ No ❑ Yes ❑ N/A

Who does your child live with? ❑ Both parents ❑ Mother ❑ Father ❑ Other

Number of people living in your home: ______

Are your living conditions appropriate/sufficient? ❑ No ❑ Yes

Is your child's primary language English? ❑ No, list primary language: ______ ❑ Yes ______

As the parent/guardian of this child, is English your primary language? ❑ No, list: ______ ❑ Yes ______

How do you prefer information for teaching/instructions?

❑ Written materials ❑ Audio (listening) ❑ Visual (pictures) ❑ Any of those listed

Family History

Mother's name: ______ Age: ______ Occupation: ______

Father's name: ______ Age: ______ Occupation: ______

Marital status: ❑ Never married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Living arrangements of parents: ❑ Living together ❑ Living apart

Family History (continued)

Please indicate any of the following that a member of your family currently has or has had in the past.

❑ Birth defects	❑ Cancer	❑ Hay fever	❑ Thyroid problems
❑ Obesity	❑ Alcoholism	❑ Hepatitis	❑ Arthritis
❑ DES exposure	❑ Diabetes	❑ Asthma	❑ Psychiatric disorder
❑ Mental retardation	❑ Cystic fibrosis	❑ High blood pressure	❑ Sexually transmitted disease
❑ Headaches	❑ Anemia	❑ Heart disease	
❑ Allergies	❑ Epilepsy	❑ Stroke	

Safety/Housing Concerns

Do you have smoke detectors in your home? ❑ No ❑ Yes

Do you have carbon monoxide detectors in your home? ❑ No ❑ Yes

Does anyone smoke in your home? ❑ No ❑ Yes

Do you have any nutritional concerns? ❑ No ❑ Yes

Does your child drink dairy/milk? ❑ No ❑ Yes (1-3 cups daily) ❑ Yes (3-6 cups daily)

Does your child have access to unlocked cupboards containing harmful substances? ❑ No ❑ Yes

Does your child have a car/booster seat that is age appropriate? ❑ No ❑ Yes ❑ N/A

Are you concerned about any type of abuse in your home? ❑ No ❑ Yes

Do you have any pets? ❑ No ❑ Yes

What type of home do you live in? ❑ House ❑ Apartment ❑ Mobile home

Do you own or rent your current home? ❑ Own ❑ Rent

How old is your home? ________________ years

Number of bedrooms: ________________ Number of bathrooms: ____________

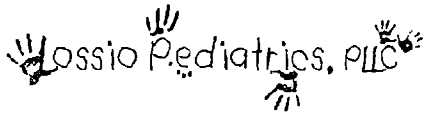
Water source: ❑ Well ❑ City well ❑ Other

Heat source: ❑ Gas ❑ Oil ❑ Other

Thank you for taking the time to complete this form. The information you provide will be helpful in planning your child's health care.

Signature of person completing this form: ______________________________

Relationship to the patient: ______________________________ Date:_____ / _____ / _____



Adolescent Health History

Ages 13-18 years

Date: ____________________

Name: ____ Age: ______ Birthdate: ______________

Sex: ❑ Male ❑ Female Grade in School: ______________ Religion: ______________________

Reason for visit: ____

Current Health Status: ❑ Excellent ❑ Good ❑ Fair ❑ Poor Date of Last Physical: ______________

Please place a mark in the box next to any of the following that you have:

❑ Hearing problems ❑ Difficulty seeing ❑ Difficulty reading ❑ Other disabilities

If "other" is marked please list: ____

How do you prefer to learn? ❑ Written/visual material ❑ Verbal teaching

Is your primary language English ❑ Yes ❑ No If no, please list: ______________________

Have you ever had any surgeries: ❑ Yes ❑ No If yes, please list: ______________________

Medical History: (check if you currently have or have had in the past)

❑ Chest pain
❑ Depression
❑ Excessive hunger
❑ Excessive thirst
❑ Earache
❑ Ear Drainage
❑ Fainting
❑ Headache
❑ Allergies/Hayfever
❑ Weight loss
❑ Constipation
❑ Diarrhea
❑ Nausea
❑ Vomiting
❑ Shortness of Breath
❑ Rash
❑ Nosebleeds
❑ Sinus Problems
❑ Blood in Urine
❑ Painful Urination
❑ Persistent Cough
❑ Irregular/rapid heart beat
❑ Vision Problems

Check any of the following illnesses you have or have had:

❑ Measles
❑ Mumps
❑ Rubella
❑ Roseola
❑ Chicken Pox
❑ Scarlet Fever
❑ Rheumatic Fever
❑ Polio
❑ Diphtheria
❑ Pertussis (whooping cough)
❑ Aids
❑ Alcoholism
❑ Anemia
❑ Anorexia
❑ Asthma
Other: ______________________________________
❑ Cancer
❑ Diabetes
❑ Epilepsy
❑ Heart Disease/Murmur
❑ Venereal Disease
❑ Hepatitis

Males Only:

Do you have pain in your testicles: ❑ Yes ❑ No

Do you do self testicular exams: ❑ Yes ❑ No

Do you have a discharge from your penis? ❑ Yes ❑ No

Do you have a sore on your penis? ❑ Yes ❑ No

Females Only:

At what age did your period start ________________

How often is your period ____________________ How many days does your period last ________________

Do you experience pain with your periods? ❑ Yes ❑ No

Have you ever been pregnant? ❑ Yes ❑ No

Do you do self breast exams? ❑ Yes ❑ No

Prenatal History:

Where were you born: ________________________ Were you premature: ____________________________

Did you have any complications or problems at birth: ❑ Yes ❑ No

If yes what were they? ____

Did your mother smoke, or use alcohol and/or drugs during pregnancy? ❑ Yes ❑ No

If yes, what was it? ____

Hospitalizations/Surgeries/Injuries:

List all including date, where, and why, and any outpatient procedures

1. ____
2. ____
3. ____
4. ____
5. ____

Current Medications:

	Name	Dosage	When Prescribed
1.			
2.			
3.			
4.			
5.			

Do you take any over the counter medications? ❑ Yes ❑ No (If yes please list)

Allergies:

Medications: ________________ ________________ ________________

Foods: ________________ ________________ ________________

Other: ________________ ________________ ________________

Ever been tested for allergies: ❑ Yes ❑ No If yes when ________ Results ________________

Immunizations: (list date of last or "X" if never received)

MMR: ______________________ Tetanus Booster: ______________________

DPT: ______________________ Pneumonia: ______________________

Polio: ______________________ TB Test: __________ results: __________

HIB: ______________________ Hepatitis B: __________ titer results: __________

Flu: ______________________

Self Care/Health habits: (the following includes questions regarding current health habits, sexuality and use of drugs and alcohol, please answer honestly, all information is considered confidential and will not be shared with anyone other than your healthcare provider without your permission)

1. Are you often sad or depressed? ❑ Yes ❑ No
2. Are you often nervous or tense? ❑ Yes ❑ No
3. Do you feel something is wrong with your weight? ❑ Yes ❑ No
4. Have you ever thought of killing yourself? ❑ Yes ❑ No
5. Have you ever been in trouble at school? ❑ Yes ❑ No
6. Have you ever been in trouble with the police? ❑ Yes ❑ No
7. Is there violence or abuse in your home: ❑ Yes ❑ No
8. Have you ever been touched in a way that made you feel uncomfortable? ❑ Yes ❑ No
9. Have you ever been physically, emotionally or sexually abused? ❑ Yes ❑ No
10. Do you have a boyfriend or girlfriend? ❑ Yes ❑ No
11. Have you been or are you currently sexually active? ❑ Yes ❑ No
12. Do you use birth control? ❑ Yes ❑ No
13. What type of birth control do you use? (check all that apply)
    - ❑ Birth control pills ❑ Condoms
    - ❑ Depoprovera ❑ Diaphragm
    - ❑ Spermicidal gels/foam ❑ Withdrawal
    - ❑ Nothing ❑ Other: ______________________
14. Please check any of the following substance you are currently using or have used in the past?
    - ❑ Cigarettes ❑ Cocaine/Crack
    - ❑ Chewing tobacco/Snuff ❑ Glue/Aerosol Cans
    - ❑ Marijuana ❑ LSD/PCP/Peyote
    - ❑ Steroids ❑ Beer/Wine
    - ❑ Amphetamines/Speed ❑ Liquor such as whiskey, vodka etc.

Any other drugs or alcoholic beverages you use or have used: ______________________

____

15. Do you feel that you have a problem with drugs or alcohol? ❑ Yes ❑ No
16. Do you feel anyone in your family has a problem with alcohol or drug use? ❑ Yes ❑ No
17. Has anyone ever told you that you have problem with drugs or alcohol? ❑ Yes ❑ No
18. Do you have any questions regarding sex, sexuality, birth control, alcohol or drug use or any other questions regarding your health? ❑ Yes ❑ No

Family History: check if your blood relatives have had any of the following

- ❑ Arthritis
- ❑ Asthma
- ❑ Cancer
- ❑ Diabetes
- ❑ Heart Disease
- ❑ Hypertension
- ❑ Tuberculosis
- ❑ Glaucoma
- ❑ Epilepsy
- ❑ Kidney Disease
- ❑ Thyroid Disease
- ❑ Stroke
- ❑ Mental Illness
- ❑ Chemical Dependency

____

____

Thank you for taking the time to complete this form. The Information you provided will be helpful in planning your heath care.

Person completing form: ______________________ Relationship if not patient: ______________________

NEW PATIENT INFORMATION SHEET
PLEASE COMPLETE ALL SECTIONS AND RETURN TO RECEPTIONIST

PATIENT_______________________________________ ADDRESS_______________________________
(First) (Last) (Middle Initial)

DATE OF BIRTH_______________________________ CITY_______________________________

PHONE (__________)_________________________ STATE/ZIP_______________________________

PT'S SOCIAL SECURITY NUMBER_______________________________ PT GENDER: MALE / FEMALE

PARENT/LEGAL GUARDIAN (Mom)_______________________________(Dad)_______________________________

PARENT/LEGAL GUARDIAN'S EMPLOYER (Mom)_______________________(Dad)_______________________

PRIM INS_______________________________ SECOND INS_______________________________

SUBSCRIBER NAME_______________________________ SUBSCRIBER NAME_______________________________

SUBSCRIBER'S DATE OF BIRTH_______________________ SUBSCRIBER'S DATE OF BIRTH_______________________

SUBSCRIBER'S SOC SEC #_______________________ SUBSCRIBER'S SOC SEC #_______________________

RLNSHIP TO SUBSCRIBER_______________________ RLNSHIP TO SUBSCRIBER_______________________

GROUP #_______________________________ GROUP #_______________________________

CONTRACT #_______________________________ CONTRACT #_______________________________

PERSON TO CONTACT IN CASE OF EMERGENCY/PHONE____

ALTERNATE EMERGENCY CONTACT/PHONE____
(Not living at same address as first contact)

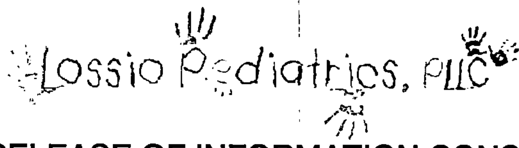
DRUG ALLERGIES____

Lossio Pediatrics, PLLC participates with a variety of health care plans including Medicaid, Molina Medicaid, most Michigan BCBS Plans, Blue Care Network, ConnectCare, Aetna, Cofinity, Health Care Alliance Pool, The Chandler Group, McLaren Commercial and Medicaid; MidMichigan Health Plan, CIGNA, Priority Health, HealthPlus, Midland Health Plan, Central Health Plan, Physicians Health Plan, and TriCare/Tricare Prime. Participation means that we hve a contract with these insurance companies and must accept their "allowable" fee as payment in full. Deductibles, co-pays and non-covered services are not included. If we do not participate with your insurance carrier, you may still have a balance after your insurance company has paid. If your insurance plan is not listed, please check with your insurance carrier and/or your employer to ask about participation prior to receiving any services. Participation is subject to change. As a courtesy to our patients, Lossio Pediatrics, PLLC submits claims to all carriers, regardless of our participation status with them. Patients are responsible for paying any applicable co-pay and deductible amounts on the day service is rendered, or for paying in full if we do not participate with your health care plan.

I understand that my insurance policy is a contract between myself and my insurance company. Therefore, I am responsible for all fees regardless of insurance coverage at the time services are rendered. I agree to be financially responsible for all costs incurred by my dependent child in connection with medical examinations, treatments, referrals, testing and/or procedures ordered by this office, whether conducted in this office or elsewhere, which are not otherwise paid by my insurance.

I hereby authorize Lossio Pediatrics, PLLC or its designees to bill and release to my insurance company and/or third party payor(s) and/or external review agency(s) such information contained in my child's patient record as is necessary for the payment of insurance benefits without regard to any limitations placed on dates, history or illness or diagnostic and therapeutic information.

Signature:____ Date:_______________________________
(LEGAL PARENT OR GUARDIAN)



RELEASE OF INFORMATION CONSENT

At times we receive requests by our patients and their family members regarding the patient's health status and other health management information (lab results, tests results, medication refills or changes, etc.)

To protect your patient confidentiality, we ask your permission to release this information to individuals you specify below. If you are unavailable or become incapacitated, which individuals do you approve our release of information to?

Please take time to fill out this form with the requested information. If an individual you have indicated requests information about you or for you, we will ask their address and phone number to be sure they are the one you designated. If you do not have all the information with you, please take this form home with you for completion and return it to us at your convenience.

NAME(S) OF PERSON(S) YOU AUTHORIZE US TO RELEASE INFORMATION TO:

____________________ Name | ____________________ Relationship

____________________ Address | ____________________ Phone Date of birth

____________________ Name | ____________________ Relationship

____________________ Address | ____________________ Phone Date of birth

____________________ Name | ____________________ Relationship

____________________ Address | ____________________ Phone Date of birth

I, ____________________ give ____________________ permission to release medical information (health status report, lab or test results, medication refill or medication changes) regarding my treatment and ongoing health care needs to the persons(s) I have indicated above.

____________________ Witness Signature | ____________________ Patient Signature

____________________ Date | ____________________ Date

Providers will share patient information with other providers who are involved in the patient's care, as appropriate. The data sharing may be through written medical information or through electronic sharing of information.

LOSSIO PEDIATRICS, PLLC

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The undersigned Patient or legally authorized representative ("Agent") of the Patient acknowledges that he or she personally received a copy of the NOTICE OF PRIVACY PRACTICES of LOSSIO PEDIATRICS, PLLC on the date indicated below.

Signature: ______________________________ Date: ________________

Patient: ________________________________

Information about Agent (attach appropriate documentation):

Agent: ____

Title: ____

FOR OFFICE USE ONLY

❑ Patient/Representative Unable to Sign - Notice of Privacy Practices Provided

❑ Patient/Representative Refused to Sign - Notice of Privacy Practices Provided

❑ Other ____

Signature: ______________________________ Date: ________________

Print Name: ____

Lossio Pediatrics, PLLC

Release of Information Authorization

I authorize the use or disclosure of the below named individual's health information as described in this document.

The following Individual or Organization is authorized to make the disclosure: ______________________

The type of Information to be used or disclosed : __Consultation Reports __EKG's __X-Ray Reports

__Laboratory Reports __Discharge Summaries __Emergency Records __Operative Reports

__History&Physicals __Pathology Reports ___Entire Record

I understand that the information in my Health Record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome(AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol or drug abuse.

This information may be disclosed to and used by the following: Lossio Pediatrics, PLLC
245 Warwick Dr., Ste D Alma, MI 48801

__**Self** __**Other**______________________________________

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition:______________________________.
If I fail to specify an expiration date, event or condition, this authorization will expire in six(6)months from date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need to sign this form in order to assure treatment. I understand that I may inspect a copy of the the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization.

Patient Name:______________________________DOB:____________Phone:____________________

Mailing Address:__________________________City:______________State:________Zip:__________

Patient/Parent Signature:______________________________Date:______________________

Staff Signature:____________________________________

Screening Checklist for Contraindications to Vaccines for Children and Teens

PATIENT NAME ______________________

DATE OF BIRTH ____ / ____ / ____ (month / day / year)

For parents/guardians: The following questions will help us determine which vaccines your child may be given today. If you answer "yes" to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

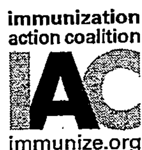
	yes	no	don't know
1. Is the child sick today?	☐	☐	☐
2. Does the child have allergies to medications, food, a vaccine component, or latex?	☐	☐	☐
3. Has the child had a serious reaction to a vaccine in the past?	☐	☐	☐
4. Has the child had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy?	☐	☐	☐
5. If the child to be vaccinated is 2 through 4 years of age, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	☐	☐	☐
6. If your child is a baby, have you ever been told he or she has had intussusception?	☐	☐	☐
7. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	☐	☐	☐
8. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
9. In the past 3 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?	☐	☐	☐
10. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
11. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	☐	☐	☐
12. Has the child received vaccinations in the past 4 weeks?	☐	☐	☐

FORM COMPLETED BY ______________________ DATE ________

FORM REVIEWED BY ______________________ DATE ________

Did you bring your immunization record card with you? yes ☐ no ☐

It is important to have a personal record of your child's vaccinations. If you don't have one, ask the child's healthcare provider to give you one with all your child's vaccinations on it. Keep it in a safe place and bring it with you every time you seek medical care for your child. Your child will need this document to enter day care or school, for employment, or for international travel.



Technical content reviewed by the Centers for Disease Control and Prevention

Saint Paul, Minnesota • 651-647-9009 • www.immunize.org • www.vaccineinformation.org

www.immunize.org/catg.d/p4060.pdf • Item #P4060 (10/16)