Patient Health History Form

COMMUNITY CARE PEDIATRICS LATHAM
of Community Care Physicians

Child's Name: _____ **Date of Birth:**_____ **Age:** _____
Today's Date:_____ **Preferred Pharmacy:** _____
Previous Pediatrician (Name and Location): _____

PREGNANCY/DELIVERY:

1. Is this your child by □ Birth □ Adoption □ Foster □ Other _____
2. Birth weight: _____ Birth length: _____ **Type of delivery**: □ Vaginal □ C-section
   Birth hospital: _____
3. Was your baby born full term? □ Yes □ No, premature at _____ weeks
4. Were there any complications of the pregnancy? □ No □ Yes _____
5. Were there any complications of the delivery/newborn period? □ No □ Yes _____
   _____

HEALTH HISTORY:

1. Any history of medical problems?_____
   _____
2. Any surgeries in the past? □ No □ Yes _____
3. Please list all medications your child takes: _____
4. Does your child have any allergies to medications or foods? □ No □ Yes _____
5. Has your child been seen by a dentist? □ Yes □ No When was the last visit? _____

DEVELOPMENTAL HISTORY:

1. At what age did your child:
   - Sit Alone _____ - Walk Alone _____ - Say words _____ - Toilet Train _____
2. Girls: When was your first menstrual period? _____

SOCIAL HISTORY:

Who lives at home with your child [including parent(s)]?

Name	Age	Relationship	Occupation

Are the child's parents:
□ Married □ Unmarried
□ Separated □ Divorced
□ Other

Does anyone smoke at home or outside the home?
□ Yes □ No

Any concerns for lead exposure at home?
□ Yes □ No

Do you feel safe at home?
□ Yes □ No

FAMILY HISTORY:

Is there any family history of the following medical problems (in child's siblings, parents, grandparents, aunts/uncles)? If present, please indicate who.

- □ Heart disease _____
- □ Heart attack _____
- □ Diabetes _____
- □ High Blood Pressure _____
- □ Obesity _____
- □ Stroke _____
- □ Asthma _____
- □ Bleeding Disorders _____
- □ Seizures _____
- □ Genetic Diseases _____
- □ Thyroid Disease _____
- □ Psychiatric Disorders _____
- □ Alcohol/Drug Dependency _____
- □ Other _____

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REVIEW OF SYSTEMS:

Has your child had any of the following issues over the past 2 weeks?

Constitutional
- ☐ Fevers, chills, excessive sweating
- ☐ Unexplained weight loss

Eyes
- ☐ Squinting
- ☐ "Lazy eye"
- ☐ Blurry vision
- ☐ Itchy eyes

Ears/Nose Throat
- ☐ Difficulty hearing
- ☐ Mouth breathing/snoring
- ☐ Frequent runny nose
- ☐ Problems with teeth/gums

Respiratory
- ☐ Cough
- ☐ Wheeze

Gastrointestinal
- ☐ Nausea, vomiting, diarrhea
- ☐ Constipation
- ☐ Blood in the stool

Cardiovascular
- ☐ Tires easily with exertion
- ☐ Shortness of breath
- ☐ Fainting

Genitourinary
- ☐ Bedwetting
- ☐ Pain on urination
- ☐ Discharge from genitals

Neurologic
- ☐ Headaches
- ☐ Weakness
- ☐ Clumsiness

Muscular
- ☐ Muscle/joint pain

Skin
- ☐ Rashes
- ☐ Unusual Moles

Psychiatric/Development
- ☐ Anxiety/depression
- ☐ Issues with sleep
- ☐ Nail biting/thumb sucking
- ☐ Bad temper/jealousy
- ☐ Speech problems

Blood/Lymph
- ☐ Unexplained lumps
- ☐ Easy bruising/bleeding

Vaccine Policy Statement

Patient's Name: _____
Date of Birth: _____

We strongly agree with the American Academy of Pediatrics (AAP) and Centers for Disease Control (CDC) that vaccines help to maintain healthy children and communities. As medical professionals, **we feel that vaccinating children following the recommended schedule with currently available vaccines is absolutely the right thing to do for all children and young adults**. We firmly believe that:

- Vaccines prevent serious illness and save lives.
- Vaccines are safe.
- Vaccines DO NOT cause autism or other developmental disabilities.
- Vaccines may be the single most important intervention we perform as healthcare providers.

Our policy at Latham Pediatrics is that:

- We follow the American Academy of Pediatrics (AAP) Immunization Guideline and CDC Immunization Schedule
- **We require all patients to be vaccinated**- barring specific medical exceptions (immunodeficiency, etc.)
- If despite our recommendations, you refuse to vaccinate your child, we ask you to find another healthcare provider who shares your views.

Please recognize that by not vaccinating, you are putting your child and others around you at unnecessary risk for life threatening illness, disability, and even death.

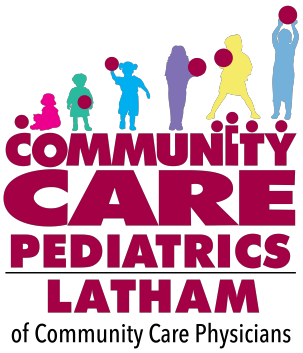
ATTESTATION:

I agree with the vaccine policy of Latham Pediatrics. My child will be vaccinated: □ YES □ No

_____ _____
Parent/Guardian Signature Date

Community Care Pediatrics - Latham
6 Wellness Way, Suite 102, Latham, NY
Phone: 518-713-2099 Fax 518-783-7506

Melissa Deimling, MD
Heather Matott, MD
Sarah Aluck, PNP
Amanda Dvorscak, DO
Hunter MacDonald, DO
Jessica Lawson, CPNP-PCNP
Kristina Lahtinen-Aley, MD
Kate Woll, MD, FAAP
Jenna Warner, NP



Patient Authorization

Who is authorized to bring the child for medical care?

I,_____ (name of custodial parent), give permission for_____ to bring my child/children in for medical care.

What can they consent to?

_____ Vaccine Administration

_____ Medication to be given to my child in office

Can another authorized caregiver verbally communicate with us over the phone? If yes who? Relationship? _____

_____

To whom can we release medical information or health forms?

_____ School

_____ Daycare/Babysitter

_____ Camp/Sport Club

_____ Other

This permission will remain in effect until I withdraw permission in written form.

_____ Child's Name _____ Date of Birth

_____ Child's Name _____ Date of Birth

_____ Child's Name _____ Date of Birth

Parental Signature _____ Date _____

COMMUNITY CARE
PHYSICIANS, P.C.
www.communitycare.com

Previous Physician:
Name: _____
_____
Location: _____
_____
_____
Phone: _____
Fax: _____

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize _____ to use and/or disclose certain protected health information (PHI) about me to:

Person or Entity to Receive the Information:

Latham Pediatrics 6 Wellness Way, Suite 102 Latham, NY 12110	**Phone**: 518-713-2099 **Fax**: 518-783-7506

This authorization permits the entity above to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of service, level of detail to be released, origin of information, etc.):

_____

_____

The information will be used or disclosed for the following purpose:

__ **Transfer of care** _____

If requested by the patient, purpose may be listed as "at the request of the individual."

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on: _____.
{Expiration Date or Defined Event}

Unless specified otherwise above, this authorization shall expire one year from the date below.

The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to my personal physician.

_____
Signature of Patient or Legal Guardian

_____
Print Name of Patient

Relationship to Patient: _____

Patient Date of Birth: _____

Date: _____