

Initial History Questionnaire

FORM COMPLETED BY _____

DATE COMPLETED _____

Name _____

ID NUMBER _____

BIRTH DATE _____

AGE _____

M F

Household

Please list all those living in the child's home.

Name	Relationship to child	Birth date	Health problems

Are there siblings not listed? If so, please list their names, ages, and where they live. _____

What is the child's living situation if not with both biological parents?

Lives with adoptive parents Joint custody Single custody

Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home? _____

Birth History Don't know birth history

Birth weight _____ Was the baby born at term? _____ OR _____ weeks

Were there any prenatal or neonatal complications?

Yes No Explain _____

Was a NICU stay required? Yes No Explain _____

During pregnancy, did mother

Use tobacco Yes No Drink alcohol Yes No

Use drugs or medications Yes No Used prenatal vitamins

What _____ When _____

Was the delivery Vaginal Cesarean If cesarean, why? _____

Was initial feeding Formula Breast milk How long breastfed? _____

Did your baby go home with mother from the hospital?

Yes No Explain _____

General DK = don't know

Do you consider your child to be in good health? Yes No DK Explain _____

Does your child have any serious illnesses or medical conditions? Yes No DK Explain _____

Has your child had any surgery? Yes No DK Explain _____

Has your child ever been hospitalized? Yes No DK Explain _____

Is your child allergic to medicine or drugs? Yes No DK Explain _____

Do you feel your family has enough to eat? Yes No DK Explain _____

Biological Family History DK = don't know

Have any family members had the following?

Childhood hearing loss	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Nasal allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Heart disease (before 55 years old)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
High cholesterol/takes cholesterol medication	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Bleeding disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Dental decay	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Cancer (before 55 years old)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____

(Biological Family History continued on back side.)

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



Initial History Questionnaire

Biological Family History (Continued from front side.) DK = don't know

Liver disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Kidney disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Diabetes (before 55 years old)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Bed-wetting (after 10 years old)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Obesity	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Epilepsy or convulsions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Alcohol abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Drug abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Mental illness/depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Developmental disability	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Immune problems, HIV, or AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Tobacco use	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Additional family history _____					

Past History DK = don't know

Does your child have, or has your child ever had,	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	When _____
Chickenpox	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Frequent ear infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Problems with ears or hearing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Nasal allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Problems with eyes or vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Asthma, bronchitis, bronchiolitis, or pneumonia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Any heart problem or heart murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Anemia or bleeding problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Blood transfusion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Organ transplant	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Malignancy/bone marrow transplant	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Chemotherapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Frequent abdominal pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Constipation requiring doctor visits	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Recurrent urinary tract infections and problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Congenital cataracts/retinoblastoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Metabolic/Genetic disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Kidney disease or urologic malformations	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Bed-wetting (after 5 years old)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Sleep problems; snoring	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Chronic or recurrent skin problems (eg, acne, eczema)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Frequent headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Convulsions or other neurologic problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Obesity	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Thyroid or other endocrine problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
History of serious injuries/fractures/concussions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Use of alcohol or drugs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Tobacco use	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
ADHD/anxiety/mood problems/depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Developmental delay	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Dental decay	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
History of family violence	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Sexually transmitted infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Pregnancy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
(For girls) Problems with her periods	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Has had first period	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Age of first period _____	
Any other significant problem _____				

This American Academy of Pediatrics Initial History Questionnaire is consistent with Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, 3rd Edition.

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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JOLIET PEDIATRIS & FAMILY CARE

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Bolingbrook, IL 60440
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REGISTRATION

PLEASE PRINT

Date _____ Home Phone () _____ Cell Phone () _____

PATIENT INFORMATION

Name _____ SS/HIC/PATIENT ID# _____
Last Name First Name Middle Initial
Address _____ E-mail _____
City _____ State _____ Zip _____
Sex M F Age _____ Birthday _____
 Married Widowed Single Minor
 Separated Divorced Partnered for _____ years
Patient Employers/School _____ Occupation _____
Employer/School Address _____ Employer/School Phone () _____
Whom may we thank for referring you? _____
In case of emergency who should be notified? _____ Phone () _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial
Relationship to patient _____ Birth date _____ Soc. Sec. # _____
Address (If different from parents) _____ Phone () _____
City _____ State _____ Zip _____
Person Responsible Employed by _____ Occupation _____
Business Address _____ Business Phone () _____
Whom may we thank for referring you? _____
In case of emergency who should be notified? _____ Phone () _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? Yes No
Subscriber Name _____ Birth date _____ Relationship to Patient _____
Address (If different from parents) _____ Phone () _____
City _____ State _____ Zip _____
Subscriber Employed by _____ Business Phone () _____
Insurance Company _____ Soc. Sec. # _____
Contact # _____ Group # _____ Subscriber # _____
Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of patient, parent, Guardian or Personal Representative

Date

Please print name of patient, parent, Guardian or Personal Representative

Relationship to Patient

CONSENT/AUTHORIZATION FORM

Sher Ahsan K Niazi MD
Mark Joseph Brinkman MD
Edgar Torres MD

Pamela Meduga-Lopina APN
Michelle Maloney APN
Judith Bartels APN

CONSENT FOR TREATMENT: I authorize the above named providers, to perform the treatment/procedure(s), along with the expected benefits, risks, possible alternative methods of treatment, and possible consequences involved in the following:

1. Physical Exams
2. Vaccinations & Treatments of any kind as needed

I understand that the treatment/procedure(s) will be explained to me in detail and the doctor/nurse practitioner will answer my questions in full. Understanding this I authorize the above named providers to perform such examinations, treatments, laboratory tests, and administer such medications as in his or her opinion, are necessary for

Name of Patient

I also certify that no guarantee assurance has been made as to the results that may be obtained.

RELEASE OF MEDICAL RECORD: In order to ensure proper follow-up and continuity of care, I agree that a copy of my medical record may be released to my physician, a designated referral physician, and/or the provider, if any, who referred me here.

INSURANCE AUTHORIZATION: I request that payment of authorized benefits be made to the above named providers on my behalf, for any services provided to me. I authorize any holder of medical and other information about me to release to Medicare assistance agency, or any other governmental or private payer responsible for paying such benefits, any information needed to determine these benefits or benefits for related services. I agree to pay all charges not covered by third party payer. I authorize a copy of this authorization to be used in place of the original.

Signature: _____
Parent/Guardian Signature

Date: _____

JOLIET PEDIATRICS AND FAMILY CARE

PATIENT RECORD OF DISCLOSURES

In general, the HIPPA privacy rule gives individuals the right to request a restriction on use and disclosures of their protection health information (PHI). The individual is also proved the right to request confidential communication or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Home Telephone _____
<input type="checkbox"/> Ok to leave message with detailed information
<input type="checkbox"/> Leave message with call-back number only

<input type="checkbox"/> Work Telephone _____
<input type="checkbox"/> Ok to leave message with detailed information
<input type="checkbox"/> Leave message with call-back number only | <input type="checkbox"/> Written Communication
<input type="checkbox"/> Ok to mail to my home address
<input type="checkbox"/> Ok to mail to my work/office address
<input type="checkbox"/> Ok fax to this number
Other _____
_____ |
|--|---|

_____ Parent signature

_____ Date

_____ Patient Name

_____ Birth date

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosures of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These providers do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute and adequate record.

Note: uses and disclosures for TPO may be permitted without prior consent in an emergency

Record of Disclosures of Protected Health Information

DATE	Disclosed whom address or fax number	(1)	Description of disclosure/purpose of disclosure	By whom disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized
 (2) Type key: T=treatment Records; P=Payment Information; O:Healthcare Operations
 (3) Enter how disclosure was made: F=Fax; P=Phone; E=Email; O=Other

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (“HIPPA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment follow-up among the multiple healthcare providers, who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change the *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain the copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my restrictions, but if you agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____