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Sabrina McDaniel-Colburn, CRNP *
K. Presley Rutland, CPNP *

* Associate Providers

PARTNERS WITH PARENTS FOR THE HEALTH OF THEIR CHILDREN

Dear Parents,

Welcome to Partners in Pediatrics!

We are thrilled to have you and your child join our family. As part of our commitment to providing the best care possible, we want to ensure that your child's first visit with us is smooth and efficient. To help us achieve this, we kindly ask you to complete the registration and history forms enclosed in this packet prior to your appointment.

By completing these forms ahead of time, you'll not only save valuable time during your visit but also help us gain a better understanding of your child's medical history and any specific needs they may have. This allows us to tailor our care to meet your child's unique requirements.

Please understand that all new patient paperwork must be completed by the **patient's parent or legal guardian.** Stepparents, grandparents, or other relatives may only complete the paperwork if they have been granted legal custody and can provide the appropriate documentation.

To make the process as convenient as possible, we've included Adobe Fill & Sign-enabled PDF forms. You can easily fill them out electronically using your computer, tablet, or smartphone.

From a Computer:

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From a tablet or smartphone:

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2. /ÐÅÎ ÔÈÅ &ÏÒ Í Óţ $Ï × ÎÌÏÁÄ Q ÓÁÖÅ ÔÈÉÓ ÄÏÃÕ Í ÅÎÔ ÔÏ ÙÏÕÒ ÄÅÖÉÅÅ ÁÎÄ ÏÐÅÎ ÔÈÅ Í ÕÓÉÎÇ !ÄÏÂÅ &ÉÌÌ Q 3ÉÇÎ8 9ÏÕ ÄÁÎ ÅÁÓÉÌÙ ÆÉÌÌ ÔÈÅ Í ÏÕÔ ÅÌÅÃÔÒÏÎÉÃÁÌÌÙ ÕÓÉÎÇ ÙÏÕÒ ÄÅÖÉÅÅ›Ó ËÅÙÂÏÁÒÄ ÏÒ ÓÔÙÌÕÓ8

After filling out the forms, save the completed documents to your device. Once completed, you can securely submit the forms back to us via email at **forms@mypartnersinpediatrics.net** or print bring them with you to your appointment. Please attach a copy of your Driver's License to the email for verification purposes.
Should you encounter any difficulties or have any questions while filling out the forms, please don't hesitate to reach out to our friendly staff. We're here to assist you every step of the way.

Thank you for choosing Partners in Pediatrics for your child's healthcare needs. We look forward to meeting you and providing excellent care to your little one.

PARTNERS IN PEDIATRICS, LLC

PATIENT REGISTRATION FORM

*****PLEASE PRINT & PROVIDE ALL INFORMATION BELOW*****

PRIMARY PHYSICIAN

○ Wood ○ Brannon ○ Blakeney ○ Diebel ○ Mukkamala ○ McNally ○ Speight ○ Hooper ○ Schull ○ Troy ○ Scott ○ Rutland

PATIENT INFORMATION

First *Middle* *Last* *Preferred Name* *Social Security #*

○ M ○ F

Date of Birth *Sex* *Race* *Ethnicity* *Religion* *Preferred Language*

ALLERGIES: **Does your child have any known Drug/other Allergies?** _____

Do we see any other children in your family? ○ **Yes** ○ **No** **List Each:** _____

FAMILY INFORMATION

Child lives with: ○ ***Parents*** ○ ***Mother*** ○ ***Father*** ○ ***Grandparent*** ○ ***Foster Parent*** ○ ***Other:*** _____

Primary Family Email Address: _____ ***(Best Email for Reminders, Notices and Information)***

Primary Family Phone Number _____ ***(Best Phone Number for Reminders)***

Parent/Legal Guardian Name

First *Middle* *Last*

Relationship to Child: _____

Street Address *City,State,Zip*

Home Phone *Cell Phone*

Authorization to Contact by Cell Phone and/or Text ○ *Yes* ○ *No*

DOB *Social Security #*

Employer *Work #*

Drivers License # *State*

Parent/Legal Guardian Name

First *Middle* *Last*

Relationship to Child: _____

Street Address *City,State,Zip*

Home Phone *Cell Phone*

Authorization to Contact by Cell Phone and/or Text ○ *Yes* ○ *No*

DOB *Social Security #*

Employer *Work #*

Drivers License # *State*

Parent/Guardian Status ○ **Single** ○ **Married** ○ **Divorced** ○ **Widowed** **If divorced, who has legal custody:** _____

Legal Documents Provided: ○ **Yes** ○ **No - If yes specify:** _____ **Other:** _____

EMERGENCY CONTACT & AUTHORIZED PERSON(S)

List Person(s) to contact in case of an emergency other than parent/legal guardian and/or person(s) authorized to bring child to visits and have access to "ALL" patient medical and financial information.

Name/Phone Number: _____ **Relationship to Patient:** _____

Name/Phone Number: _____ **Relationship to Patient:** _____

Name/Phone Number: _____ **Relationship to Patient:** _____

Name/Phone Number: _____ **Relationship to Patient:** _____

INSURANCE INFORMATION

PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD AND DRIVERS LICENSE

PRIMARY INSURANCE

Insurance Company

Primary Insurance Holder Name *DOB*

Member ID # *Group ID #*

Employer

SECONDARY INSURANCE

Insurance Company

Primary Insurance Holder Name *DOB*

Member ID # *Group ID #*

Employer

CONTINUED

PARTNERS IN PEDIATRICS, LLC

PATIENT REGISTRATION FORM

CONTINUED

POLICIES & PROCEDURES

PLEASE READ CAREFULLY, INITIAL AND SIGN AUTHORIZATION BELOW

Initial ___ **INSURANCE:** Partners in Pediatrics, LLC accepts assignment of insurance benefits from most major insurance companies for payment of services on your behalf. It remains your responsibility to verify coverage with our physicians and your specific policy before treatment. Our business office is ready to assist you with your coverage questions.

Initial ___ **CO-PAY:** Your insurance policy and the agreement between your physician and the insurance company requires that we collect a co-pay per patient per visit. The parent or authorized person must pay co-pays at the time of service. If a co-pay is not made at the time of service, then an additional $10.00 service charge is added to your account.

Initial ___ **SELF-PAY:** If your child does not have medical coverage or is out of the network, then you must see the business office before treatment. You are responsible for all charges incurred at the time of service. The business office will assist you with the amount due. You may receive a copy of your itemized billing statment for insurance or tax purposes.

Initial ___ **NO SHOW:** As a courtesy, we will provide reminders for your appointment. If you are unable to make your scheduled time, then you must notify our office 24 hours prior to that time. Missing three (3) scheduled appointments will result in dismissal from the practice.

Initial ___ **HOSPITALIZATION:** In the event of hospitalization we will file the hospital charges incurred for the physician treating your child. If newborn patient charges are incurred, then it is your responsibility to add the newborn to your policy or another acceptable policy within 30 days of date of birth. If no insurance is acquired, then you will be responsible for all newborn hospital charges and all subsequent office visit charges if any.

Initial ___ **AGREEMENT TO PAY:** In case of default of payment and if this account is placed in the hands of a collector, collection agency or attorney, then all collection fees, attorney's fees, (33.33%) court costs and all other expenses related to the collection of the outstanding balance will be paid by the undersigned. You agree, in order to service your account or to collect monies you may owe, Partners in Pediatrics, LLC and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice message and/or use of automatic dialing device, as applicable.

Initial ___ **PRIVACY:** I acknowledge that I have read your Notice of Privacy Practices in accordance with The Health Portability & Accountability act of 1996 (HIPAA) and have been offered a copy of it.

AUTHORIZATION AND PERMISSION FOR TREATMENT

I acknowledge I have read and understand the disclosures, billing policies of Partners in Pediatrics, LLC and I am responsible for payment. I, as the parent, guardian or legal personal representative, give my permission to Partners in Pediatrics, LLC and their employees to provide medical care to my child. I realize I am responsible for accompanying my child or children while on the premises. According to HIPAA law, I shall update this information at least annually or sooner if any change occurs.

Signature of Parent or Guardian **Date**

OFFICE USE ONLY

Rev. 07112024

You may print the completed packet and bring to the appointment or email to forms@mypartnersinpediatrics.net.
Please attach a copy of your DL and Insurance card to the email.

Partners in Pediatrics, LLC

Partners with Parents for the health of their children

NEW PATIENT POLICY

Patient Name _____ **DOB** _____

- ***Partners in Pediatrics, LLC*** requires completed new patient paperwork before an appointment. This paperwork includes the Registration Form, New Patient Questionnaire, HIPAA Consent Form and HIPAA Notice of Privacy Practices. All forms are available on our website at www.mykidsdr.com under the "New Patients" tab.
- All new patient paperwork must be completed by the patient's parent or legal guardian. Stepparents, grandparents, or other relatives may only complete the paperwork if they have been granted legal custody and can provide the appropriate documentation.
- If the patient is a minor (younger than 18 years), they **MUST** be accompanied by a parent or legal guardian to the first appointment. The parent or legal guardian may designate an authorized representation to accompany the patient to future appointments
- Each responsible party is required to furnish a current and valid picture ID, driver's license, etc. which will be copied for our records at the time of your appointment.
- A copy of the current health insurance card is required and will be copied for our records at the time of your appointment.
- All newborn new patients coming to the office must be added to their appropriate health insurance policy by the parents **within 30 days** of the date of birth. If the infant is not added within 30 days, you will be responsible for payment in full.
- To be established as a patient in our practice, other than a newborn, we will schedule your initial appointment while we are waiting to receive your records. You may bring in or submit any medical records or immunizations that would be vital to your child's care. Please keep in mind that a checkup may be required in order to obtain all the information needed to fill out future required forms or referrals in providing continuity of care. If you have had a check up in the last year, please notify our staff as your insurance may not cover a second check up.
- If your health insurance requires a co-payment or you have not met your deductible then a payment will be required **at check-in** on the date of the first visit, newborns included. Our practice has a contractual obligation with your insurance company to collect payments at the time of service. We accept cash, checks and all major credit cards.
- Bring any medical records, x-rays, MRI scans, CT scans or any other studies you have recently completed at other facilities so we can add them to your chart for our reference. If at any time you obtain medical services at another facility you will provide those records so we can incorporate them into you chart.
- Provide any information for any medications you are currently taking.

By signing below, I agree to follow the new patient policy of *Partners in Pediatrics, LLC*.

_____ _____

Parent or Guardian **Date**

Catherine L. Wood, M.D.
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Sabrina McDaniel-Colburn, CRNP
K. Presley Rutland, CRNP

* Associate Physician

PARTNERS WITH PARENTS FOR
THE HEALTH OF THEIR CHILDREN

Consent for the Use and Disclosure of Protected Health Information

Use and Disclosure of Your Protected Health Information
Your protected health information will be used by Partners in Pediatrics, LLC or disclosed to others for the purposes of treatment, obtaining payment or supporting the day to day health care operations of the practice.

Notice of Privacy Practices
You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use and Disclosure of Your Information
You may request a restriction on the use and disclosure of your protected health information.

Partners in Pediatrics, LLC may or may not agree to restrict the use and disclosure of your protected health information. If Partners in Pediatrics, LLC agrees to your request, the restriction will be binding on the practice. Use and disclosure of protected health information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use and disclosure that has already occurred prior to the date on which your revocation of your consent is received will not be affected.

Reservation of Right to Change Privacy Practices
Partners in Pediatrics, LLC reserves the right to modify the privacy practices outlined in the notice.

Signature
I have reviewed this consent form and give my permission to Partners in Pediatrics, LLC for the use and disclosure of my health information in accordance with this consent.

Patient Name: _____

Signature (Parent or Guardian): _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

Catherine L. Wood, M.D.
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K. Presley Rutland, CRNP

*** Associate Physician**

PARTNERS WITH PARENTS FOR THE HEALTH OF THEIR CHILDREN

PATIENT PORTAL RELEASE

Our Patient Portal offers you a convenient, anytime access to patient health information and puts YOU at the center of your healthcare. With the ability to view accurate health records, lab results, and communicate with your doctor, you are helping us to expand and improve your health care experience!

Always dial 911 for emergency situations. DO NOT leave a message on the Patient Portal as it could take 24-48 hours for a response.

I further acknowledge:

- I understand it is my responsibility to maintain the confidentiality of the information contained in the documents.

- I understand the patient portal should NOT be used for emergency situations.

- I understand messages **will not** be addressed if received from any individual who is not currently authorized on my Registration Form to obtain such information according to HIPAA patient health information (PHI) privacy rules.

Primary email address: _____

A link to register will be sent to this email address.

Patient Name: _____ D.O.B: _____

Patient/Guardian Signature:_____ Date: _____

8160 Seaton Place ▪ Montgomery, Alabama 36116 ▪ (334) 272-1799 ▪ Fax: (334) 272-4876
8134 Seaton Place ▪ Montgomery, Alabama 36116
688 Covered Bridge Pkwy ▪ Prattville, Alabama 36066
136 East Main Street ▪ Prattville, Alabama 36067

Immunization Policy Statement

Partners in Pediatrics, LLC is committed to practicing medicine in compliance with the evidence-based guidelines established by groups of experts such as the **American Academy of Pediatrics, Centers for Disease Control and Prevention**, and the **Advisory Committee on Immunization Practices.**

We have a firm policy on vaccination as we believe so strongly in the safety and efficacy of vaccines. Furthermore, we also have a duty to protect our community as well as our patients who are unable to receive certain vaccines (either due to young age or due to being immunocompromised, etc).

At Partners in Pediatrics, we firmly believe:

- in the safety and effectiveness of vaccines to prevent serious illness and to save lives;
- that all children and young adults should receive all of the recommended vaccines* according to the schedule published by the Centers for Disease Control and the American Academy of Pediatrics;
- based on all available literature, evidence and current studies, that vaccines do not cause autism, weakened immune systems or other developmental disabilities;
- that vaccinations may be the single most important intervention we perform as health care providers and the most important health intervention that you choose for your children.

The recommended vaccines and the published schedule are the results of years of scientific study and the accumulation of data on millions of children by the brightest scientist and physicians in our country. Vaccines prevent infections that can be extremely debilitating and/or life-threatening such as pertussis or whooping cough, measles, *Haemophilus influenza type B* meningitis, and pneumococcal blood infections.

Unfortunately, the vaccine campaign is truly a victim of its own success. It is precisely because vaccines are so effective at preventing illness that parents are discussing whether or not they should be given. Because of vaccines, most parents have never seen a child with bacterial meningitis or even chickenpox; most people have never heard of a friend or family member who died from one of these diseases. Such successes can make us complacent about the need for vaccination. Unfortunately, this will likely lead to tragic results. In countries where there are low vaccination rates, these illnesses are still quite prevalent. In the US and in other well-developed countries, communities with under-immunized patients are showing a rise in these once-rare diseases. As we have witnessed with the recent measles outbreak, a resurgence of these diseases can occur unless we continue to immunize children.

We present these facts not to scare or coerce you, but to emphasize the importance of vaccinating your child. We recognize that the choice may be a very emotional one for some parents. We will do everything we can to provide education and information regarding the recommended vaccines so that you can make an informed decision for your child. However, should you have doubts, please discuss these with your health care provider. **Delaying or "breaking up the vaccines" to give one or two at a time over two or more visits can put your child at risk for serious illness or death** and goes against our medical advice as providers.

It is for these reasons that Partners in Pediatrics requires all patients to be vaccinated according to the recommended schedule.*

While we are happy to answer questions and discuss the safety and efficacy of the vaccines, if parents chose to not begin routine vaccinations by the time their child is 6 months old, they will be expected to find a different primary care office. Additionally, we will not accept transfers of unvaccinated children over the age of 6 months into our practice. Children who transfer to Partners in Pediatrics will be given 30 days in which to provide confirmation of all childhood vaccines that are currently due per the AAP's vaccine schedule or will need to initiate vaccinations within those 30 days.

As medical professionals, we feel very strongly that vaccinating children on schedule with currently available vaccines is absolutely the right thing to do for all children and young adults. Thank you for your time in reading this policy and we will gladly address any additional items you would like to discuss on an individual basis.

By signing below, I acknowledge that I have read and understand the immunization policy of Partners in Pediatrics, LLC.

_____ _____

Parent/Guardian Name Date

**PIP's minimum vaccination requirements are not inclusive of all vaccines, and there are other vaccines that are also very important in keeping children healthy (e.g. flu/influenza, COVID-19, Hepatitis A, HPV vaccines).*

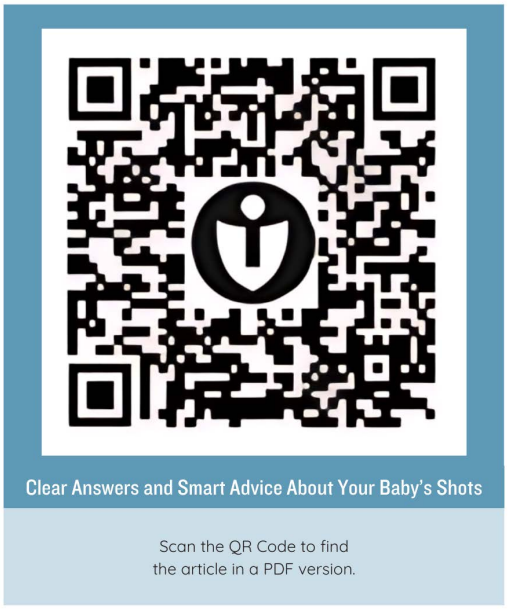
Partners in Pediatrics, LLC

Partners with Parents for the Health of their Children

We encourage any parent who wants to learn more to visit the following websites with reliable, scientific information to explain all aspects bout immunizations from manufacturing, to how they work to protect children, to data regarding safety and efficacy.

Find vaccine education here:

Clear Answers and Smart Advice About Your Baby's Shots," an excerpt from the popular book "Baby 411" by Dr. Ari Brown – www.immunize.org/catg.d/p2068.pdf



Vaccine Education Center at the Children's Hospital of Philadelphia
www.chop.edu/centers-programs/vaccine-education-center

-Q&A Vaccine sheets available in English and spanish

CDC Recommended Vaccine Schedule

Partners in Pediatrics Initial History Questionnaire

This form should be completed by a parent or legal guardian.

Patient Name BIRTH DATE ☐ M ☐ F

CHART NUMBER (OFFICE USE) AGE DATE COMPLETED

MOTHER'S NAME AGE

OCCUPATION

FATHER'S NAME AGE

OCCUPATION

Household

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

Name	Relationship to child	Birth date	Health problems

Do you live in a house, apartment, mobile home, or other? _____

Is your drinking water from the tap (public system) or well? _____

Are there any smokers in the household? ☐ Yes ☐ No

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 ☐ Other _____

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

Are there any problems with the condition of your home? (peeling paint, mold, insects, rats, or mice) ☐ Yes ☐ No _____

Are there any guns in the home? ☐ Yes ☐ No

Any swimming pools in the house? ☐ Yes No

Birth History ☐ Don't know birth history

Mother's age at birth of child _____ Prenatal Care Doctor _____

How many weeks pregnant when child delivered? _____ weeks

Birth weight _____

Did mother have any illness or prenatal complications during pregnancy?

☐ 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? _____

Did the baby have any trouble starting to breathe? ☐ Yes ☐ No

Did the baby have any trouble while in the hospital? (jaundice, infections, other?) ☐ Yes ☐ No Explain _____

Was a NICU stay required? ☐ Yes ☐ No Explain _____

Was initial feeding ☐ Formula ☐ Breast milk How long breastfed? _____

If formula-fed, which one do/did you use? _____

General DK = don't know

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

Where has your child gone for check-ups until now? _____

Date of last check-up: _____ Last dental check-up: _____

Immunizations up-to-date? ☐ Yes ☐ No ☐ DK

Has your child ever been hospitalized? ☐ Yes ☐ No

If yes, explain _____

Any serious injuries? ☐ Yes ☐ No ☐ DK

If yes, explain _____

Is your child allergic to any medications, foods, or insect bites? ☐ Yes ☐ No

If yes, explain _____

Has your child had any surgeries or procedures? ☐ Yes (List with dates) ☐ No

_____

_____

_____

Are any medications taken regularly? ☐ Yes (Please list with doses) ☐ No

_____

_____

_____

Review of Medical History

Please check if your child has had any of the following medical problems:

- ☐ ADD/ADHD
- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety/Depression
- ☐ Asthma
- ☐ Autism
- ☐ Bedwetting
- ☐ Bleeding disorder
- ☐ Bronchiolitis
- ☐ Chicken pox
- ☐ Concussion
- ☐ Constipation
- ☐ Dental Decay
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Eczema/Hives
- ☐ Frequent colds
- ☐ Frequent Strep or sore throat
- ☐ Fracture
- ☐ Handicaps/Disabilities
- ☐ Headaches
- ☐ Hearing problems
- ☐ Heart murmur
- ☐ Congenital heart disease
- ☐ High blood pressure
- ☐ Kidney disease
- ☐ Liver disease/Hepatitis
- ☐ Recurrent ear infections
- ☐ Recurrent cough
- ☐ Pneumonia
- ☐ Reflux/GERD
- ☐ Seizures
- ☐ Thyroid Disorder
- ☐ Urinary Tract Infections
- ☐ Vision problems

☐ Problems with Periods (Girls) Age of first period _____

☐ Other: _____

OTHER PROVIDERS: (Please list any other specialists your child sees.

Ex: physical therapy, ENT, etc)

_____

_____

_____

Initial History Questionnaire - Page 2

Partners in Pediatrics, LLC
Partners with Parents for the Health of their Children

Patient Name _____ CHART NUMBER (OFFICE USE ONLY) _____

Development/Behavior

Where does the child reside during the day? _____
At what age did your child sit alone? _____
At what age did he/she walk alone? _____
Did he/she say any words by the time he/she was 1½ years old? ☐Yes ☐No
Does this child compare to others his or her age? ☐Yes ☐No
Does he/she have any trouble sleeping? ☐Yes ☐No
What grade is he/she in? _____
Has he/she had any trouble in school? ☐Yes ☐No
Does he/she get along with other children? ☐Yes ☐No
Does he/she have and IEP or 504 plan? ☐Yes ☐No

Daycare/School? _____
Check if your child has had any of the following:

☐ nail biting	☐ bad temper	☐ speech problems
☐ thumb sucking	☐ hyperactivity	☐ problems with discipline
☐ bed wetting	☐ nightmares	☐ problems with toilet training

Other: _____

Adolescents:
Does your child smoke? ☐Yes ☐No Vape? ☐Yes ☐No
Use drugs? ☐Yes ☐No Sexually Active? ☐Yes ☐No
Drink alcohol? ☐Yes ☐No Have history of depression? ☐Yes ☐No
Drink caffeine? ☐Yes ☐No Suicide attempts? ☐Yes ☐No

Feeding & Nutrition

Is your child's appetite usually good? ☐Yes ☐No ☐DK
Any severe colic or any feeding problems during the first year? ☐Yes ☐No ☐DK
Do any foods disagree with him/her? ☐Yes ☐No ☐DK
What type of milk does your child drink?
☐Whole ☐2% ☐Soy ☐Other _____
☐Breast Milk ☐Formula (type) _____
How many ounces of milk is typically consumed in 24 hours? _____
How many ounces of juice/soda does your child drink per day? _____

Special Diet? _____
Does he/she take vitamins? ☐Yes ☐No ☐DK
Has your child had any problems with growing? ☐ Yes ☐No ☐DK
Does your child eat non-food materials (dirt/paper, etc)? ☐Yes ☐No
If yes, what: _____
Do you feel your family has enough to eat? ☐ Yes ☐ No ☐ DK

Biological Family History DK = don't know

Have any family members had the following?

Childhood hearing loss	☐ Yes	☐ No	☐ DK	Who _____
Nasal allergies	☐ Yes	☐ No	☐ DK	Who _____
Asthma	☐ Yes	☐ No	☐ DK	Who _____
Tuberculosis	☐ Yes	☐ No	☐ DK	Who _____
Heart disease (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____
High cholesterol	☐ Yes	☐ No	☐ DK	Who _____
High blood pressure	☐ Yes	☐ No	☐ DK	Who _____
Anemia	☐ Yes	☐ No	☐ DK	Who _____
Bleeding disorder	☐ Yes	☐ No	☐ DK	Who _____
Stroke	☐ Yes	☐ No	☐ DK	Who _____
Sudden Death	☐ Yes	☐ No	☐ DK	Who _____
Dental decay	☐ Yes	☐ No	☐ DK	Who _____
Cancer (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____
Liver disease	☐ Yes	☐ No	☐ DK	Who _____
Kidney disease	☐ Yes	☐ No	☐ DK	Who _____
Diabetes (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____
Bed-wetting (after 10 years old)	☐ Yes	☐ No	☐ DK	Who _____
Obesity	☐ Yes	☐ No	☐ DK	Who _____
Epilepsy or convulsions	☐ Yes	☐ No	☐ DK	Who _____
Other inherited/genetic disorder	☐ Yes	☐ No	☐ DK	Who _____
Alcohol abuse	☐ Yes	☐ No	☐ DK	Who _____
Drug abuse	☐ Yes	☐ No	☐ DK	Who _____
Mental illness/depression	☐ Yes	☐ No	☐ DK	Who _____
Developmental disability	☐ Yes	☐ No	☐ DK	Who _____
Immune problems, HIV, or AIDS	☐ Yes	☐ No	☐ DK	Who _____
Tobacco use	☐ Yes	☐ No	☐ DK	Who _____

Additional family history
_____
_____
_____
_____
_____
_____
_____