Tuscaloosa Pediatrics, PC
4880 Harkey Lane
Tuscaloosa, Alabama 35406
Telephone 205-333-8222
Fax 205-333-8233

Transfer Request

Date: _____

Name of Child/Children/Date of Birth:

_____ _____

_____ _____

Are your child's immunizations up to date: _____ YES ____ NO

If not, why not? _____

Current Physician: _____

Reason you would like to transfer: _____

_____

_____

Please list all specialists or physicians that your child/children have seen or are seeing:

_____

_____

Please list all chronic medical problems: _____

_____

You will be responsible to pay for your visit at the time of service until we can verify your insurance.

Please be aware that our office does not accept all insurances. There are some insurance companies that have a Patient Panel that allow maximum number of patients. If our panel is full or you change to an insurance we do not accept you will be asked to find a new physician.

Please be aware that if you are a new patient and fail to show up for your 1st scheduled appointment without giving at least a 24 hour notice, you may be asked to find another medical office or physician for medical care.

_____ _____

Signature of Parent Date

Tuscaloosa Pediatrics, PC
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Tuscaloosa, AL 35406
Telephone: 205-333-8222
Fax: 205-333-8233

HIPAA Authorization for Release of Information

Patient Name: _____ _____ _____
First Middle Initial Last

Date of Birth: ____/____/____ Home Phone: ____/____/____

Address: _____

City: _____ State: _____ Zip Code: _____

I hereby authorize Tuscaloosa Pediatrics, P.C. to obtain my medical records from:

Name: _____

Street Address/P.O. Box: _____

City: _____ State: _____ Zip Code:_____

Telephone #:_____ Fax #:_____

Information to be released is to include: (Please circle Yes or No)

All Physician Notes	YES	NO
Treatment Summary	YES	NO
X-Ray Reports	YES	NO
Laboratory Reports	YES	NO
Itemized Bill	YES	NO

Other (Specify) _____

_____ _____
Parent/Legal Guardian Signature Date

_____ _____
Relationship to Patient Expiration Date of Release

I understand the information released will be limited to information necessary to fulfill the need or purpose for the disclosure. If I have authorized the disclosure of information to a recipient who is not subject to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), then the recipient may re-disclose it and it may no longer be protected under HIPAA, a federal privacy law. This Authorization is valid for 90 days from the date of signature. This Authorization only applies to treatment occurring before the date of signature, I may decline to sign this Authorization. I understand I may revoke this authorization in writing at any time by completing a form available from Tuscaloosa Pediatrics, P.C. If I revoke this authorization, the revocation will not apply to information that has already been released in response to the authorization. I understand the patient's health care and the payment for the patient's health care will not be affected if I do not sign this form. I understand I may see and copy the information described on this form if I ask for it, and I may receive a copy of this form after I sign it. Before requesting medical record copies, please ask about the copy fee by law that may apply. I represent that I have the authority to and voluntarily grant permission for the information to be released as described above.

TUSCALOOSA PEDIATRICS

4880 HARKEY LANE, TUSCALOOSA, AL 35406
PHONE: 205-333-8222
FAX: 205-333-8233

Dear Parents,

In an effort to provide continuity for our patients, we are asking you to circle your first and second choice of physician when completing our demographic forms. We will make every attempt to make sure your child is scheduled with one of these physicians for all of his or her check-ups. We will ideally try to keep you with the same physician each time but in the event that particular physician is not available, we will try to put you with your second choice. If you desire to change and begin using a physician you did not originally schedule as a first or second choice, please let our front office know.

If you have a particular physician you would prefer for sick visits, it is best that you call and make an appointment with that physician. The walk-in clinic is staffed with different physicians each day. Patients are pulled back in order of arrival and then put with the next available physician. Therefore, we cannot guarantee you will see the physician of your choice when visiting the walk-in clinic. However, we are confident that any one of our physicians will provide good care to your child.

We are honored that you have chosen us to provide medical care for your child and hope this will help us to optimize that care.

Thank you,

Tuscaloosa Pediatrics, PC

Tuscaloosa Pediatrics, P.C.

___ Denise Brown, M.D.
___ Allison Cunningham, M.D.
___ Joy Dean, M.D.
___ Megan McGiffert, M.D.

Select 1st & 2nd Choice Physician

___ Michelle Parchman, M.D.
___ Kaila Sullivan, CRNP
___ Julie Vaughn, M.D.

Account #: _____ Date: _____

Name you prefer we call your child: _____

Last: _____ First: _____ Middle Name: _____

Date of Birth: _____ Sex: Male_____ Female_____

Home Address: _____

City: _____ State: _____ Zip: _____

Sibling: _____ DOB _____ Sibling: _____ DOB _____

Sibling: _____ DOB _____ Sibling: _____ DOB _____

Ethnic Group: Hispanic Non Hispanic **Race:** Asian Black White Other_____

Language: Arabic English German Korean Spanish Other_____

Mother Stepmother Guardian

Name: _____
Cell Number: (_____)_____
Work Number: (_____)_____
E-mail Address: _____
Employer: _____
Occupation: _____
Marital Status: _____

Father Stepfather Guardian

Name: _____
Cell Number: (_____)_____
Work Number: (_____)_____
E-mail Address: _____
Employer: _____
Occupation: _____
Marital Status: _____

Emergency Contact (other than parent): _____ Phone#: _____

Patient's cell phone number if age 14 years or older. (State of AL Age of Consent is 14) _____

Primary Insurance

Insurance Co: _____
Policy Holder: _____
Contract/ID#: _____
Group #: _____
Effective Date: _____
Relation to Child: _____
Policy Holder Date of Birth: _____

Secondary Insurance

Insurance Co: _____
Policy Holder: _____
Contract/ID#: _____
Group #: _____
Effective Date: _____
Relation to Child: _____
Policy Holder Date of Birth: _____

Does your insurance require a Primary Care Doctor or any type of Physician Referral? _____
Does your insurance require you to use a specific lab or x-ray facility? ___ If so, which one? _____

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Consent to Receive Cell Phone Calls or Text Messages

As a service to our clients we provide a courtesy appointment reminder call and possibly other important calls that may be placed using a pre-recorded message. By providing your cell phone you consent to receive such calls or text messages on your cell phone. If you do not want to be contacted in the above manner, please do not provide your cell phone number when you complete the Demographics information.

Parent/Patient Signature: _____

Date: _____

TUSCALOOSA PEDIATRICS
PERMISSION TO ACCESS PRESCRIPTION HISTORY

I, _____, whose signature appears below, authorize Tuscaloosa Pediatrics PC providers and staff to view the prescription history via the Retail Prescription Hub service for the patient listed below.

_____ _____

Patient Name (Please Print) Patient Date of Birth

By initialing, you are agreeing to the respective terms and conditions set below and are fully agreeing to the terms above.

_____, I understand that the prescription history is from multiple other unaffiliated medical providers, insurance companies and pharmacy benefit managers and may be viewable by my providers and staff here, and it may include prescriptions back in time for the last 2 years.

My signature certifies that I have read and understand the above and that I authorize the access.

_____ _____ _____

Signature of Parent/Guardian Relationship to Patient Date

Tuscaloosa Pediatrics, P.C.
4880 Harkey Lane
Tuscaloosa, AL 35406

HIPAA Authorization Statement

(Please complete the following so we may contact you properly & securely)

Please list the family members or to the persons, if any, whom we may inform about your child's general medical condition and diagnosis (including treatment, payment, and healthcare operations).

Name _____

Phone # _____

Name _____

Phone # _____

Please list the family member or significant others, if any, whom we may inform about you r child's medical condition ONLY IN CASE OF EMERGENCY.

Name _____

Phone # _____

Name _____

Phone # _____

If you would like your billing statement and/or correspondence from our office to be sent to an address other than you home, please list below.

Name _____

Address _____

Please list the telephone number(s) you would like to be contacted at for appointment, lab, and x-ray results or other health care information if other than your home telephone number. (Please be aware that a cell phone is not a secure and private line).

Telephone #_____ Telephone #_____

Can confidential messages be left on your voicemail? YES / NO

Can confidential health information be sent via text? YES / NO
(This method of communication is not secure and you are electing to communicate via unsecure text)

_____
Patients Name (Please Print)

_____
Signature (Parent/Guardian if under 18 years of age)

Tuscaloosa Pediatrics Vaccine Policy

We firmly believe in the effectiveness of vaccines to prevent serious illness and to save lives.

We firmly believe in the safety of the vaccines we provide.

We firmly believe that all children and adolescents should receive all of the recommended vaccines according to the schedule published by the Centers for Disease Control and the American Academy of Pediatrics.

We firmly believe, based on all the available literature, evidence, and current studies, that vaccines do not cause autism or other developmental disabilities. We firmly believe that thimerosal, a preservative that has been in vaccines for decades and remains in only a very few vaccines now, does not cause autism or other developmental disabilities.

We firmly believe that vaccinating children and adolescents may be the most important health-promoting intervention we provide to your child as their pediatrician. The recommended vaccines and the schedule by which they are given are the results of years and years of scientific study and data gathered on millions of children around the world by thousands of our brightest scientists and physicians.

This being said, we recognize that there has always been and will likely continue to be controversy surrounding vaccination. The vaccine campaign is truly a victim of its own success. It is precisely because vaccines are so effective at preventing illness that many people do not understand the severity of the illnesses we are trying to prevent. Because of vaccines, many people have never seen a child with polio, tetanus, whooping cough, bacterial meningitis, or even chickenpox. Less than a century ago these illnesses were commonplace and they caused the majority of early infant and childhood deaths. The success of vaccines has led our generation to complacency about vaccinating which can have tragic results.

Over the past two decades, many people in Europe chose not to vaccinate their children with the MMR vaccine due to a fraudulent study suggesting a link between the MMR vaccine and Autism Spectrum Disorder. This resulted in multiple outbreaks of measles in Europe. The results of this study have since been proven false multiple times by numerous follow-up studies. But these outbreaks still occur and they are not without complications including permanent neurologic deficits and several deaths. There is a fatal, progressive disorder called Subacute Sclerosing Panencephalitis that only occurs 7-10 years after a natural measles infection so consequences may be still to come from these outbreaks.

While Europe and these disease outbreaks may seem a long distance from us in the United States, they are really only a plane ride away. We have had our own outbreaks of measles, mumps, Hemophilus Influenza B meningitis, meningococcal meningitis, and whooping cough in the U.S. in the past few years. These cases have mainly occurred in unvaccinated babies, children, and even adults.

We are making sure you are aware of these facts not to scare or coerce you, but to emphasize the importance of vaccinating your child. We recognize that the decision to vaccinate your child may be a very emotional one for some parents. Should you have doubts, please discuss them with us. Please be advised, however, that delaying or "breaking up the vaccines" to give one or two at a time goes against expert recommendations, and it can put your child at risk for serious illness or death. This goes against our medical advice as physicians at Tuscaloosa Pediatrics.

Should you absolutely refuse to vaccinate your child, you will be asked to find another health care provider who shares your views.

We appreciate the trust you have put in us to care for your children. Thank you for reading this policy. Should you have any questions we will be happy to discuss them during your office visit. We have several handouts available regarding vaccines and the diseases they prevent. We also have links to reliable vaccine information sites on our website www.tuscaloosapeds.com and we encourage you to look closely at those.

Thank you,
The Physicians of Tuscaloosa Pediatrics

I, _____, have read the above Tuscaloosa Pediatrics Vaccine Policy and I plan to vaccinate my child according to the recommended vaccination schedule from the American Academy of Pediatrics and the Centers for Disease Control.

_____ _____ _____

Signature | Relationship to Patient | Date

Tuscaloosa Pediatrics Financial and Office Policies

** PLEASE INITIAL ALL BELOW THAT YOU ACKNOWLEDGE AND AGREE **

_____ Please be aware if you are a new patient and fail to show up for your 1st appointment without giving a 24 hour notice, you may be asked to find another medical office or physician for medical care.

_____ Please be aware our office does not accept all insurances. You may be asked to transfer out of the practice if you change to an insurance we do not accept, change to a plan we are no longer participating with, or our enrollment for your insurance is full at that time.

_____All professional services rendered by Tuscaloosa Pediatrics, P.C. are charged to the patient. We will gladly file your insurance for you. However, the parent or guardian is responsible for all fees that are not covered by the insurance.

_____ We are required to report visits outside of normal business hours to your insurance provider. Any appointment scheduled before 8am, after 5pm, and on Saturday or Sunday will incur an additional fee. This fee will be billed to your insurance provider, but may be applied to your copay, coinsurance, or annual deductible.

_____ Payment is due at time services are rendered (such as co-pays, deductibles and non covered services) regardless of who brings the patient in for his/her visit. There will be a $15.00 administrative fee added to your account if your co-pay is not paid at the time of service. We accept cash, check, Visa, and MasterCard.

_____ We feel strongly about children having routine well check-ups. Per American Academy of Pediatrics, children should receive preventative health care at the ages listed below. We expect our parents to follow these guidelines so that we may continue to provide quality healthcare to our children. We understand there are some insurance policies that do not cover yearly check-ups, but do not feel this is a reason for your child not to have them. Failure to do so may result in being discharged from the practice.

- 3-5 days of life
- 2 weeks of age
- 1 month of age
- 2 months of age
- 4 months of age
- 6 months of age
- 9 months of age
- 12 months of age
- 15 months of age
- 18 months of age
- 24months of age
- 30 months of age
- 3-18 years of age - yearly

_____ If your child is not current on routine check-ups, any refill on chronic medications and/or any routine immunizations may be denied until your child is current on routine check-ups.

_____ No well visits or immunizations will be given if you have an outstanding account balance.

_____ It is the patient's responsibility to know your insurance benefits and whether the physicians in this practice are preferred providers. Some insurance companies require referrals to specialists and urgent care facilities. It is your responsibility to notify our office within 48 hours if you are seeing or have seen another physician. Don't assume that referrals are done if you don't speak to someone in our insurance office, even if our physicians or nursing staff refer you.

_____ We will not give referrals to urgent care facilities or emergency rooms if you go during our regular business hours unless approved in advance, for a life-threatening emergency or we instruct you to go because we are unable to schedule an appointment here in a timely manner.

_____ Most insurance companies allow 30-45 days for you to add your newborn to your insurance policy. We require you to pay for the visit in full for the 2 month check-up if we cannot verify your baby's enrollment before the visit.

Tuscaloosa Pediatrics Financial and Office Policies

_____ We must have a release signed by a parent or guardian on file to release medical records. We request your account be paid in full in order to release your medical records if you are transferring your child/children to another physician. Accounts that are not paid in full or arrangements made to do so will be treated as a bad debt and will be forwarded to a collection agency.

_____ There is a fee and a 72 hour waiting period on all medical forms, blue cards not associated with a check-up and medical record copying. Please check with the office staff in advance on the cost for each request.

_____ There is a $15.00 fee for after hours telephone calls. Please read and follow our Telephone Policy to avoid unnecessary costs.

_____ Excluding refills on chronic medications, any prescription not associated with an office visit with one of our providers may be subject to a $15.00 fee.

_____ If you do not cancel your appointment 24 hours prior to the scheduled appointment time, you will be charged a No Show/Failure to Cancel fee. Any office visit that is scheduled with a Physician will incur a $40.00 No Show/Failure to Cancel fee. Any visit scheduled with a nurse will incur a $10.00 No Show/Failure to Cancel fee. Repeat offences could result in being discharged from the practice.

_____ If you have not arrived to your appointment within 15minutes of your scheduled appointment time, we will assume you are not coming. In such case, you will be charged the missed appointment fee.

_____ There is a $25.00 fee on all returned checks.

Agreement to Accept Financial Responsibility, Insurance Authorization and Assignment of Benefits

I acknowledge that, at my request, Tuscaloosa Pediatrics, P.C. has provided my dependent with professional services and I agree to the above financial policy. I also understand that if I fail to comply with this agreement, and if my account becomes more than 90 days past due, it may be turned over to a collection agency, an attorney or small claims court for collection. I understand the collection agency charges Tuscaloosa Pediatrics a 33 1/3% fee in an effort to collect outstanding balances. This fee will be added to my bill and become my responsibility.

I hereby authorize Drs. Brown, Cunningham, McGiffert, Parchman, Vaughn and Kaila Sullivan, CRNP to furnish medical information to my insurance carriers for payment of claims. I hereby assign to the physicians all payments for the medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Communications Regarding My Account

Until my account is finally settled, I give my direct consent to receive communications regarding my account from any servicers and any collectors of my account, through various means such as 1) any cell or text number that I provide, 2) any email address that I provide, 3) auto dialer systems, 4) voicemail messages, and other forms of communications.

_____

PATIENT NAME/NAMES -- PLEASE LIST EACH FAMILY MEMBER THAT IS A PATIENT HERE

_____ _____ _____

Signature of Responsible Party | Relationship | Date

February 2023

Tuscaloosa Pediatrics, P.C.
4880 Harkey Lane
Tuscaloosa, AL 35406

Receipt of Privacy Practices Written Acknowledgement Form

I, _____ as parent or legal guardian of

_____ have received a copy of the Notice of Privacy
(Name of Child)

Practices Form from Tuscaloosa Pediatrics, P.C.

Signature of Parent or Guardian: _____ Date: _____

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	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Nasal allergies	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Asthma	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tuberculosis	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Heart disease (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
High cholesterol/takes cholesterol medication	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Anemia	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bleeding disorder	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Dental decay	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Cancer (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

(Biological Family History continued on back side.)

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

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

Liver disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Kidney disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Diabetes (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bed-wetting (after 10 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Obesity	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Epilepsy or convulsions	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Alcohol abuse	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Drug abuse	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Mental illness/depression	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Developmental disability	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Immune problems, HIV, or AIDS	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tobacco use	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

Additional family history _____

Past History DK = don't know

Does your child have, or has your child ever had,

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

Has had first period ☐ Yes ☐ 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.

HE0328

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