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 primary care physician: ____

Previous primary care physician(s): ____

Because we want to make sure our practice is a good fit for your child and your family's needs we would like to know what you are looking for in your pediatrician and their office staff?

____

____

Why did you leave (or wanting to leave) your child's current physician?

____

____

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
4880 Harkey Lane
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 better continuity of care for our patients, we are asking you to circle your first and second choice of physician when filling out the demographic data sheets. 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. This will require an approval from the chosen physician as he/she may or may not be able to handle additional patients at that time. In doing this, we hope to maintain adequate openings for all physicians so that patients can schedule with whom they desire.

If you have a particular physician you would prefer for sick visits, it is best that you call and make an appt with that physician. The clinic is staffed with different physicians each day. Therefore, we cannot guarantee you will see the physician of your choice for same day sick. However, we are confident that any one of our physicians will give 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.

Select 1st & 2nd Choice Physician

___ Denise Brown, M.D.
___ Allison Cunningham, M.D.
___ Joy Dean, M.D.
___ Megan McGiffert, M.D.
___ Michelle Parchman, M.D.
___ Julie Vaughn, M.D.
___ Paige Fancher, CRNP
___ Kaila Sullivan, CRNP

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? ________________

Tuscaloosa Pediatrics, P.C.
4880 Harkey Lane
Tuscaloosa, Alabama 35406
Phone 205-333-8222
Fax 205-333-8233

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, 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 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.

______ Please be aware that our office is open most Federal Holidays, and if your child is seen, there is a Federal Holiday code (CPT 99051) that we do charge. This fee will be billed to your insurance provider, but may be applied to your copay, coinsurance, or annual deductible. If not covered by your insurance, you will incur an additional fee for this service.

______ 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 $20.00 fee for after hours telephone calls. Please read and follow our Telephone Policy to avoid unnecessary costs.

______ 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 $50.00 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.

______ Please review our OFFICE FEES for additional forms and service fees.

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, Dean, McGiffert, Parchman, Vaughn and CRNPs, Kaila Sullivan and Paige Fancher 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

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 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.

______________________	______________________	______________
Signature	Relationship to Patient	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

Sick Complaints at a Well Child Checkup

If you bring your child to a Well Child checkup and they are also sick or they have a new medical complaint, a worsening chronic medical problem, a medical condition where they are due for a recheck/medication refill, or if a new medical issue is discovered by your physician during the visit, most insurance plans require us to file a separate visit code for these types of problems when they are addressed at a Well Child Checkup. Because of this, your insurance may require you to pay a copay or deductible like you would at a separate visit just for that problem. We know there are some physicians out there that require a separate visit to cover any new problems but we know your time is valuable and we try to address all your issues in one visit whenever possible. In these cases, it may be necessary for you to pay a copay or deductible even if your insurance does not require a copay for Well Child Checkups.

WELL VISITS typically include: Tracking growth, checking vital signs, a full physical exam, evaluating developmental milestones and/or school performance, evaluating vision and hearing, evaluating diet and nutrition, evaluation of emotional well-being, medical risks based on family history, screening labwork when indicated, routine childhood immunizations, evaluation of stable chronic medical conditions, anticipatory guidance regarding common issues at your child's age, and filling out sports physical forms if needed

EXAMPLES of a few situations in which it may become necessary for us to file a separate sick visit code are below. We are unable to give examples of every situation that could arise that insurance would require additional codes of course.

A child who has been having headaches for the past 2 months.

A child with asthma who has been having to use their inhaler more frequently over the past few weeks and requires medication changes.

A child who has a fever at their Well Check Up and requires a flu test and a prescription for an antibiotic for their newly diagnosed ear infection.

A child who is found to have a foreign body in their ear on exam.

A child who is due for their ADHD or Anxiety medication visit at the same time as their checkup.

WHY DOES IT HAVE TO BE BILLED DIFFERENTLY? It is billed differently to account for the additional work, expertise, and time required for both the Well Check Up and the Sick visit (additional lab work, x-ray, referrals and/or prescription medications). For example, think about taking your vehicle in for an oil change (routine maintenance) and mentioning to the mechanic that your brakes are squeaking and your windshield wipers are not working well. In addition to the oil change, your car might require additional work on your brakes and replacement windshield wipers. Since additional services were provided, you would be charged for more than just the oil change.

If you have any questions regarding your child's bill, our insurance department is always glad to answer any questions. You may also need to talk directly to your insurance company to understand what your plan does and doesn't cover and when a copay or deductible is required.

____________________________ Patient Name

____________________________ Patient Date of Birth

____________________________ Parent/Guardian Signature

____________________________ Date

Tuscaloosa Pediatrics
Policy for Divorced or Separated Parents

Our highest priority is the care of our patients. We have many patients whose parents are either separated or divorced and we are happy to work with either or both parents to make sure the child's healthcare needs are met.

When a child is seen in our office and accompanied by either parent, we will assume that parent has the authority to make medical decisions for the child, unless we are instructed otherwise by legal documentation.

It is essential that both parents reach an agreement regarding their child's healthcare needs prior to arriving at our office as we will not mediate disagreements. We will discuss our medical assessments and recommendations with the parent who accompanies the child to the office or contacts us by telephone or portal. However, we are happy to answer any questions regarding your child's health from either parent at any time.

Copays will be collected at the time of service by the accompanying parent or guardian, regardless of divorce decree. If the court agreement states otherwise, we will be happy to provide a receipt at the time of the visit for medical reimbursement to be settled privately between parents.

Yearly paperwork should be completed the same by each parent. Both parents need to discuss and agree on how demographics should be completed. This includes home and billing address and who should be listed on the HIPAA. Patient demographics will be updated based on the most recent update we have been given.

It is essential that parents communicate with each other regarding insurance policies. There are often times when a child has more than one insurance policy. In these situations, all policies must be made aware of each other. It is the parents' responsibility to make sure Coordination of Benefits (COB) is updated so that claims are processed and paid correctly. If we are made aware of a COB issue and it is not resolved, all insurance policies will be inactivated and patient will be considered self-pay until this issue is resolved.

Tuscaloosa Pediatrics providers and staff will not become involved in disputes between family members. Should a dispute interfere with your child's healthcare, or should an issue become disruptive to our practice, we will discharge the patient from further treatment.

______________________________	______________________________
PATIENT NAME	PATIENT DATE OF BIRTH

______________________________	____________________	__________
Signature of Parent/Legal Guardian	Relationship	Date

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

Name

ID NUMBER

FORM COMPLETED BY　　DATE COMPLETED

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?

Condition	Yes	No	DK	Who	Comments
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

Condition	Yes	No	DK	Who	Comments
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,

Condition	Yes	No	DK	When/Explain
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.

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.

Copyright © 2010 American Academy of Pediatrics. All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, recording, or otherwise, without prior written permission from the publisher.

HE0328

9-223/0109