Pediatric Health History Form (0-17 Years Old)

Demographic Information

1. Please enter the patients information.

Patient First Name: _____ Patient Middle Initials: _____ Patient Last Name: _____ Date of Birth: _____ SSN: _____

Gender:
○ Female ○ Male

Ethnicity:
☐ Hispanic ☐ Non-Hispanic
☐ Decline

Race:
☐ White
☐ American Indian
☐ Alaska Native
☐ African American
☐ Native Hawaiian
☐ Asian ☐ Other
☐ Decline

Language: _____

Street Address: _____ City: _____ Apt./Unit #: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____

Preferred contact method:
○ Mobile Phone ○ Home Phone
○ Work Phone ○ Email

Can we leave a confidential voicemail??
☐ Yes ☐ No

Reason for visit: _____

2. Is the patient under the age of 18 years old?

○ Yes ○ No

3. RESPONSIBLE PARTY (IF PATIENT IS A MINOR) Minors must be accompanied by a parent or legal guardian (please bring guardianship paperwork to the appointment).

Parent/Guardian First Name: _____ Parent/Guardian Last Name: _____ Date of Birth: _____ SSN: _____

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

4. Emergency Contact Name (First and Last): Emergency Contact Phone:

Emergency Contact Relationship
☐ Spouse/Domestic Partner ☐ Child ☐ Parent ☐ Sibling ☐ Friend ☐ Grand Parent
☐ Other Family Member

Pharmacy Name: Pharmacy Phone:

Pharmacy Address (Street and City):

5. Does the patient have a Primary Care Provider (PCP)?

○ Yes ○ No

6. Primary Care Physician (First and Last Name): Primary Care Provider Phone:

Primary Care Providers Address (some providers provide care at multiple locations):

7. How did you find us?

☐ Referring Provider/Primary Care Provider ☐ Insurance Company ☐ Social Media (Instagram, Facebook, Nextdoor, etc..
☐ Family/Friend ☐ Yelp ☐ Google
☐ Breathe Clear Institute Website ☐ Previous Patient ☐ Other (please explain below)

8. Is the patients referring provider the same as their primary care provider?

○ Yes ○ No

9. Please provide us with the referring provider information so we can keep them informed about the patients care:

Referring Providers Name (First and Last) Referring Providers Phone

Referring Providers Address (Some providers practice in multiple locations)

10. Would someone other than the parent or legal guardian bring the minor to their appointment? If yes, please complete the

○ Yes ○ No

11. Do you have health insurance?

○ Yes ○ No

12. **Primary Insurance Information, please bring a photo ID and your insurance card(s) to your appointment. Be sure to read the financial policy section regarding our in-network status with insurance carriers.**

Primary Insurance Company _____ Member ID / Policy # _____ Group Number _____

Client Relationship to Insured
○ Self ○ Spouse ○ Child ○ Other

Insured Name (First and Last): _____ Insured Date of Birth _____ Insured Gender ○ Female ○ Male

13. **Secondary Insurance**

Secondary Insurance Company _____ Member ID / Policy # _____ Group Number _____

Client Relationship to Insured
○ Self ○ Spouse ○ Child ○ Other

Insured Name (First and Last): _____ Insured Date of Birth _____ Insured Gender ○ Female ○ Male

14. **Please list anyone that we may discuss the patients diagnosis, treatment, financial and follow-up care with other than the parent/guardian listed above:**

1 _____ 2 _____

3 _____ 4 _____

☐ Check if you don't authorize us to speak to anyone other than yourself

Acknowledgement of Protected Health Information (PHI) and Notice of Privacy Practices (NPP) Receipt The Patient hereby consents to the use or disclosure of personally identifiable information (also referred to as protected health information or PHI) and patient medical record / billing information by Breathe Clear Institute in order to carry out treatment, payment and healthcare operations. The Patient should review our Notice of Privacy Practices (NPP) for a more complete description of the potential uses and disclosures of such information, the Patient has a right to review this document prior to signing this consent. This Organization has the right to change the Notice of Privacy Practices at any time. If the terms of the Notice of Privacy Practices are changed the Patient has a right to obtain a copy of the revised Notice. Patient acknowledges and agrees that this Organization may disclose the Patient's protected health information and/or medical record - billing information to the following individual(s) who are the Patient's family members, guardians, legal representatives, healthcare surrogates or have power of attorney on behalf of the patient. You can read the Notice of Privacy Practices attached to this intake form or you can also ask for a copy in our office Notice of Privacy Practices

_____ Signature _____ Date

HEALTH QUESTIONNAIRE

15. Does the patient take any over the counter medications, prescription medication or supplements?

○ Yes ○ No

16. What medications is the patient is CURRENTLY taking:

	Medications		Medications
1		2	
3		4	

17. You can upload a copy of the medication list or bring in a copy

18. Medication Allergies?

○ Yes ○ No Known Allergy

19. If yes, please list (including reaction):

	Allergy	Reaction
1		
2		
3		

20. Allergic reaction to Shellfish, Iodine, IV contrast and/or Latex?

○ Yes ○ No

If yes, specify the allergy and reaction:

_____

21. Has the patient ever had surgery?

○ Yes ○ No

22. Surgical History?

☐ Adenoidectomy ☐ Tonsillectomy ☐ Ear surgery

_____ _____ _____

☐ Ear Tubes ☐ Sinus/Nose Surgery ☐ Throat Surgery

_____ _____ _____

☐ Oral Surgery ☐ Neck Surgery (Please explain) ☐ Appendectomy

_____ _____ _____

☐ Heart Surgery (Please explain) ☐ Other Surgery (see below):

_____ _____

If other, please specify:

_____

23. Has the patient ever had problems with anesthesia?

○ Yes ○ No ○ Not sure

24. Does the patient have any metal fragments or any surgically implanted devices, plates, oral appliances, prosthesis, stents, bands, etc..

☐ Yes ☐ No

If yes, please describe:

_____

25. Medical conditions the patient has or has had:

☐ Diabetes Type I ☐ Diabetes Type II ☐ Gastroesophageal Reflux
☐ Hypertension ☐ History of blood clots ☐ Asthma
☐ Cystic Fibrosis ☐ Sleep Apnea/OSA ☐ Congenital Heart Condition
☐ Immunological disorder ☐ Liver disease ☐ Congestive Heart Failure (CHF)
☐ Hypothyroidism ☐ Hyperthyroidism ☐ Seizures
☐ None/Non-contributory

Please list any additional medical conditions:

_____

26. Cancer

○ Yes ○ No ○ Currently

If yes/currently, please specify type:

_____

27. Is the patient 13 years or older?

○ Yes ○ No

28. Does the patient smoke cigars, cigarettes and/or E-cigarettes)?

○ Yes ○ No ○ Not Anymore

29. What does the patient smoke? # Packs a day: _____ # Times a day _____ # Times a week _____ Year started: _____

_____

30. Year stopped:

_____

31. Has the patient ever been exposed to second hand smoke?

○ Yes ○ No

32. Fall Risk: Has the patient fallen lately that has required medical attention?

○ Yes ○ No

33. Vitals - Height/Weight

Height _____ Weight _____

34. Does the patient have any issues with sinus, nose or allergies?

○ Yes ○ No

35. What has the patient tried in the past to alleviate your sinus, nose and/or allergy symptoms?

☐ Nasal lavage (Neilmed or Neti pot) ☐ Intranasal corticosteriods (Nasacort, Rhinocort, Flonase, etc...)
☐ Antihistamines (Allegra, Zyrtec, Xyzal, etc..) ☐ Antibiotic therapy ☐ Nothing

What tests has the patient had in the past? Please bring previous doctors notes, CT scans, MRI's and/or Allergy testing to your appointment.

☐ CT Scan ☐ MRI ☐ Allergy Testing ☐ None

How many sinus infections has the patient had over the past year? _____

How long did the sinus infections last each time? _____

36. Does the patient have any of the following issues in regards to hearing?

	Check if yes	Please Select
Ringing in ear(s)		
If you have ringing, is it bothersome?		
Hearing Loss		
Trouble hearing in noise		
NONE		

How many ear infections has the patient had over the past year?

_____

37. Any other specific concerns about the patients health?

_____

_____

_____

_____

Consent for Treatment

Consent to Treatment I consent to receiving medical care from Steven E. Davis MD, Inc. medical care includes exams, testing, appropriate immunizations and medical treatment. My consent covers care from the medical staff and employees of Steven E. Davis MD Inc. No one has guaranteed me that the medical care will have certain results. I have the right (i) to make decisions about my health care, (ii) to refuse medical care, and (iii) to revoke this consent at any time except to the extent medical care has already been provided. I consent to let the medical staff document my condition upon and during my admission, including taking photographs moving pictures, or other pictures or videotapes. The patient or the authorized parent, guardian, responsible party or surrogate of the patient must give consent.

Signature

Date