

Dear New Patient,

We are pleased to welcome you as a patient of Middlesex Hospital Primary Care. Each and every day, the people at Middlesex Hospital Primary Care work to provide patient-centered, compassionate care to patients throughout our communities. We're proud of the association we have with one of the top hospitals in Connecticut, and we are confident that we can provide you with the best care possible. Thank you for choosing Middlesex Hospital Primary Care. We look forward to managing your health.

Sincerely,
Middlesex Hospital Primary Care

Patient Name: _____

First Appointment Date: _____

First Appointment Location: _____

First Appointment Provider Name: _____

Forms to Complete: (We will accept and we appreciate completed forms prior to your visit)

- Form 1: Authorization to Release Health Information (Used to obtain previous records)
- Form 2: Patient Information Form
- Form 3: Consent for Treatment/Release Information/Financial/HIPAA/Photo
- Form 4: Statement of Non Discrimination
- Form 5: Authorization to Disclose Health Information to Family & Friends
- Form 6: Health History Questionnaire (3 pages)

Please Bring the Following to your visit:

- Medical records (Complete and return Form 1 prior to first visit)
- Insurance card
- Required Co-Pay
- Completed patient forms (All 5 Forms)
- All medications you are currently taking, in original containers

FORM 1
AUTHORIZATION TO RELEASE HEALTH INFORMATION

Name of Patient: _____	DOB: _____
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I hereby authorize Middlesex Hospital Primary Care to release/obtain all medical information with respect to the treatment of the above referenced patient, including information relating to diagnosis or treatment of mental illness or drug or alcohol abuse and /or confidential HIV related information.

Release the Medical Records From:

Send the Medical Records To:

Method: <input type="checkbox"/> Mail <input type="checkbox"/> Pick up <input type="checkbox"/> Fax
Medical Group Name: _____
Address: _____
City : _____ State: _____ Zip: _____
Fax: (If needed): _____
Phone: _____

Method: <input type="checkbox"/> Mail <input type="checkbox"/> Pick up <input type="checkbox"/> Fax
Name: _____
Address: _____
City : _____ State: _____ Zip: _____
Fax: (If needed): _____
Phone: _____

What is the Purpose of Health Information Release

<input type="checkbox"/> Personal	<input type="checkbox"/> New Physician	<input type="checkbox"/> Social Security Disability	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Primary Care Physician	<input type="checkbox"/> Medical Ins. Claim	<input type="checkbox"/> Life Insurance	
<input type="checkbox"/> Consultation	<input type="checkbox"/> Worker's Com	<input type="checkbox"/> Attorney	

Describe the Health Information to be Released

Service Dates: from: _____ to: _____	Information Needed By: _____		
<input type="checkbox"/> Complete Medical Record	<input type="checkbox"/> Other: _____		
<input type="checkbox"/> History and Physical	<input type="checkbox"/> EKG's	<input type="checkbox"/> Laboratory Results	<input type="checkbox"/> Hospital Notes
<input type="checkbox"/> Immunization Records	<input type="checkbox"/> Pathology Reports	<input type="checkbox"/> Radiology Reports	<input type="checkbox"/> Clinic Notes
<input type="checkbox"/> Hospital Discharge Summary	<input type="checkbox"/> Operative Reports	<input type="checkbox"/> Radiology Images	<input type="checkbox"/> Billing Information

I understand that Middlesex Hospital Primary Care will not condition treatment, payment, enrollment or eligibility for benefits based on my signing this Authorization. I acknowledge that I am signing this Authorization freely, and no one has coerced or pressured me to sign the Authorization. I understand that I may revoke this Authorization at any time by providing written notice to Middlesex Hospital Primary Care. I understand that I may not be able to revoke this Authorization if Middlesex Hospital Primary Care has taken action in reliance on the Authorization, or if the Authorization was obtained as a condition of obtaining insurance coverage.

I understand that the Protected Health Information disclosed under this Authorization may be subject to re-disclosure by the recipient and no longer protected by the Federal Privacy Regulations.

I also understand that if the Protected Health Information that is disclosed under this Authorization is confidential HIV/AIDS related information or alcohol or drug abuse related information, the recipient may not re-disclose that information under Connecticut State Law.

This Authorization will expire one year from the date of signing unless I indicate an earlier date or event here: _____

_____	_____
Date:	Signature of Patient or Person granting Authorization on behalf of patient

_____	_____
Printed Name of Person Signing (If Not the Patient)	Relationship to Patient

FORM 1 (page 2)

NOTICE

Psychiatric Records and Communications

In the event that information released constitutes privileged psychiatrist-patient communications:

"The confidentiality of this record is required under chapter 899 of Connecticut General Statutes. This material shall not be transmitted to anyone without the written consent or other authorization as provided in the aforementioned statutes." (§ 52-146i)

Drugs and Alcohol Abuse Records

In the event that information released is protected by the HHS Confidentiality of Alcohol and Drug Abuse Patient Records regulations:

"This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by 42 CFR part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient." (42 C.F.R. § 2.32)

HIV Related Information

In the event that information released constitutes confidential HIV related information protected under Connecticut Law:

"This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose." Conn. Gen. Stat. 19a-585(a)

Demographics

Last Name:	First Name:	MI:
Address:		Mailing Address:
City:	State:	Zip:
Date of Birth:	Sex:	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Partnered		
Responsible Party (if under 18):		

Contact Information

Home Phone:	Cell Phone:
Appointment Reminder Preference: (choose one) <input type="checkbox"/> Home or <input type="checkbox"/> Cell If Cell: <input type="checkbox"/> Voice or <input type="checkbox"/> Text	
Email Address for Patient Portal Use:	
Emergency Contact Name:	Emergency Contact Phone:
Emergency Contact Address:	Relation to You:

Pharmacy Preference/Insurance Information

Local Pharmacy Name:	Local Pharmacy Address:
Mail Order Pharmacy:	Mail Order Pharmacy Address:
Insurance Information: <i>Please bring your insurance card to each visit</i>	

Additional Information

Race:	<input type="checkbox"/> White	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Black-African American
	<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian	<input type="checkbox"/> Native Hawaiian
	<input type="checkbox"/> Other Pacific Islander	<input type="checkbox"/> Unreported/Refused to Report	<input type="checkbox"/> Other Race
Ethnicity:	<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Refused to Report		
Preferred Language:	<input type="checkbox"/> English	<input type="checkbox"/> Spanish	<input type="checkbox"/> Other: _____

PRINT NAME: _____

DOB: _____

CONSENT FOR TREATMENT:

Permission is hereby given to the physicians and staff of Middlesex Hospital Primary Care ("MHPC"), a Middlesex Health System affiliate, to provide ordinary and necessary medical examination, diagnosis and treatment and administer such therapeutic treatment or services that the physician may order. Ordinary and necessary medical care shall include preventive and prophylactic care as well as laboratory tests, but shall not include surgery, general anesthesia, laboratory tests for which separate consent is required under the law or other extraordinary procedures. I further consent to routine immunizations for future office visits.

AUTHORIZATION FOR RELEASE OF INFORMATION:

I acknowledge that my health information, including information regarding diagnosis or treatment of mental illness, drug or alcohol abuse and/or HIV-related information, may be disclosed in accordance with law. I also understand that my health information may be maintained in an electronic health information exchange network or other electronic database, released to and accessible to all providers involved in my care regardless of their location, hospital-affiliation or specialty, and that my Middlesex Health System providers may have access to this information from other providers. I understand that this information may include my prescription history. Finally, I understand that I may be contacted by MHPC or its business associates at the primary phone number that I provided, which may be my cell phone, via phone call and/or text message, for purposes of treatment, appointment reminders and/or payment of my bills.

I specifically authorize the release of any and all information regarding diagnosis or treatment of mental illness, drug or alcohol abuse and/or HIV related information to any person or organization involved in my care or treatment and/or to any organization responsible for payment of services furnished to me. In the event that any of the foregoing information is released, I understand that state and federal law prohibits further disclosure of it without specific written consent of the person to whom it pertains or as otherwise permitted by state and federal law. Withdrawal of this authorization shall be addressed in writing to the Director of Health Information Management at Middlesex Hospital. I understand that neither MHPC nor any of its related entities or providers will condition treatment, payment, enrollment or eligibility for benefits on this authorization to release information.

FINANCIAL AGREEMENT/ASSIGNMENT OF INSURANCE BENEFITS:

I understand that I am obligated to pay MHPC for services provided to me in accordance with the rates and terms of MHPC, including a "No-Show" fee of **\$45 for a missed office visit and \$75 for a missed comprehensive physical exam or surgical procedure appointment** if I fail to appear and did not cancel at least 24 hours in advance. In consideration for services provided or to be provided to me, I hereby assign to MHPC all basic and major medical or other insurance benefits, including, without limitation, Medicare or Medicaid benefits, to cover such expenses. In connection with such assignment, MHPC is hereby authorized to contact my insurance carrier on my behalf and to obtain any and all such information (including, without limitation, copies of any plans, contract, or other documents defining or otherwise limiting the scope of insurance coverage by such carrier) as may be necessary to process any insurance claims related to my treatment by MHPC. If I am not insured, I hereby authorize MHPC to use and/or disclose my health information in order to obtain funds to cover expenses related to my treatment by MHPC. I owe and agree to pay MHPC for any and all charges not actually paid by insurance benefits, including those charges not covered by my insurance policy and those charges that my insurance company deems to be experimental or medically unnecessary. If my account is not paid, I will pay all court costs, attorney's fees and other costs incurred by MHPC to collect the balance owed. I also authorize payment directly to MHPC or the entity providing service under the above account number that would otherwise be payable to me.

HIPAA ACKNOWLEDGEMENT:

The undersigned hereby acknowledges that I have received a copy of the Middlesex Health System Joint Notice of Privacy Policy.

CONSENT FOR PHOTO IDENTIFICATION:

I consent to MHPC taking a digital photograph of my face for purposes of patient identification. The digital photograph will remain with my electronic medical chart and will not be used for other purposes without my authorization.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ, UNDERSTOOD AND AGREED TO THE FOREGOING, AND IS THE PATIENT OR HIS/HER REPRESENTATIVE.

Date

Signature of Patient or Person Granting Authorization on Behalf of Patient

If the patient has not signed this form, please print the signer's name, relationship to the patient and, if necessary, explain why the patient did not sign.

English: Middlesex Health System complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATTENTION: If you speak a language other than English, are deaf or hard of hearing, language assistance services are provided free of charge. Call 1-860-358-6000 or TTY 1-860-358-4499.

Español (Spanish): Middlesex Health Systems cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-860-358-6000 TTY: 1-860-358-4499.

Polski (Polish): Middlesex Health Systems postępuje zgodnie z obowiązującymi federalnymi prawami obywatelskimi i nie dopuszcza się dyskryminacji ze względu na rasę, kolor skóry, pochodzenie, wiek, niepełnosprawność bądź płeć. UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-860-358-6000 TTY: 1-860-358-4499.

Italiano (Italian): Middlesex Health Systems è conforme a tutte le leggi federali vigenti in materia di diritti civili e non pone in essere discriminazioni sulla base di razza, colore, origine nazionale, età, disabilità o sesso. ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-860-358-6000 TTY: 1-860-358-4499.

Português (Portuguese): Middlesex Health System cumpre as leis de direitos civis federais aplicáveis e não exerce discriminação com base na raça, cor, nacionalidade, idade, deficiência ou sexo. ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-860-358-6000 TTY: 1-860-358-4499.

Français (French): Middlesex Health Systems respecte les lois fédérales en vigueur relatives aux droits civiques et ne pratique aucune discrimination basée sur la race, la couleur de peau, l'origine nationale, l'âge, le sexe ou un handicap. ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-860-358-6000 TTY: 1-860-358-4499

繁體中文 (Chinese): Middlesex Health Systems 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-860-358-6000 TTY: 1-860-358-4499。

Kreyòl Avisyen (French Creole): Middlesex Health Systems konfòm ak lwa sou dwa sivil Federal ki aplikab yo e li pa fè diskriminasyon sou baz ras, koulè, peyi orijin, laj, enfimite oswa sèks. ATANSYON: Si w pale Kreyòl Avisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-860-358-6000 TTY: 1-860-358-4499. **Deutsch (German):** Middlesex Health Systems erfüllt geltenden bundesstaatliche Menschenrechtsgesetze und lehnt jegliche Diskriminierung aufgrund von Rasse, Hautfarbe, Herkunft, Alter, Behinderung oder Geschlecht ab. ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-860-358-6000 TTY: 1-860-358-4499.

(Hindi): Middlesex Health Systems ल कल त, कल करत और ज त, र, र ल, आ, कल त, कल करत आध र र ध आ लत त आ क लए त 1-860-358-6000 TTY: 1-860-358-4499 र करत । कल त ए उ ल ध कर ।

Русский (Russian): Middlesex Health Systems соблюдает применимое федеральное законодательство в области гражданских прав и не допускает дискриминации по признакам расы, цвета кожи, национальной принадлежности, возраста, инвалидности или пола. ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1860-358-6000 телерай: 1-860-358-4499.

(Arabic): Middlesex Health Systems يلتزم بوقاييد وحقول المدنية الفدرالية المعمول بها ولا يميز على أساس العرق أو اللون أو اصلاال أوطني أو اسن أو إعلافة أو اجلس. ملاحظة: إذا نكت تتحدث ذاكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك ابلماجن. اتصل بقرم 1-860-358-6000 (رقم هاتف اصل والمك: 1-860-358-4499).

Αλληνικά (Greek): Η Middlesex Health Systems συμμορφώνεται με τους ισχύοντες ομοσπονδιακούς νόμους για τα ατομικά δικαιώματα και δεν προβαίνει σε διακρίσεις με βάση τη φυλή, το χρώμα, την εθνική καταγωγή, την ηλικία, την αναπηρία ή το φύλο. ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-860-358-6000 or TTY 1-860-358-4499.

Tagalog (Tagalog - Filipino): Sumusunod ang Middlesex Health Systems sa mga nanaangkop na Pederal na batas sa karapatang sibil at hindi nandiskrimina batay sa lahi, kulay, bansang pinagmulan, edad, kapansanan o kasarian. PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-860-358-6000 or TTY 1-860-358-4499.

Tiếng Việt (Vietnamese): Middlesex Health System tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính. CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-860-358-6000 TTY: 1-860-358-4499.

Shqip (Albanian): Middlesex Health Systems vepron në përputhje me ligjet e zbatueshme federale të drejtave civile dhe nuk ushtron diskriminim mbi baza si raca, ngjyra, prejardhja etnike, mosha, aftësia e kufizuar ose gjinia. KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-860-358-6000 TTY: 1-860-358-4499.

Kiswahili (Swahili): Middlesex Health Systems ametimiza mahitaji ya sheria za serikali kuu na hana ubaguzi wakikabila, rangi, asili, umri, ilemavu ama jinsia. KUMBUKA: Ikiwa unazungunza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu 1-860-358-6000 TTY: 1-860-358-4499.

(Farsi): Middlesex Health Systems از قوانین حقوق دمئی دفاارل مربوطه بتعبیت می نکد و هیوگچنه بتعیضی بر اساس نژاد، رنگ پوست، الصبیت ملیتی، سن، ناتوانی یا نجسیت افراد اقبیل نمی شود. توجه: اگر به زبان افرسی گوگتف می نکید، تسهیلات زبانی بوصد ر رایگان برای شما فراهم می ابشد. اب 1-860-358-6000 TTY: 860-358-4499 متناس بگبیرد.

How to File a Complaint of Discrimination:

It is your right to file a complaint. Registering a complaint will not change our commitment to provide you the best quality of care. It is the policy of Middlesex Hospital not to discriminate due to age, sex, race, color, religion, sexual orientation, income, education, national origin, ancestry, marital status, culture, language, disability, gender identity, or who will pay the bill. Middlesex Hospital has an internal grievance procedure providing for prompt and equitable resolutions of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act (42 U.S.C. 18116) and its' implementing regulations at 45 CFR part 92, issued by the U.S. Department of Health and Human Services.

1. Contact the Compliance Coordinator in the Quality Improvement Department at 860-358-6151. Office hours are Monday through Friday 8:30 a.m. - 4:00 p.m. When the office is closed, you may leave a voicemail, and a staff member will return your call on the next business day.

2. In situations that require immediate assistance contact the department manager or contact the hospital operator (by dialing "0" internally or when calling from home dial 860-358-6000) and ask to speak to the nursing supervisor. You may also contact the U.S Department of Health and Human Services, Office of Civil Rights. A person can file a complaint of discrimination electronically through the Office of Civil Rights Complaint Portal, which is available at <https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf>, or by mail at: U.S Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, Complaint forms are available at: <http://www.hhs.gov/ocr/office/file/index.html>. Such complaints must be filed within 180 days of the date of the alleged discrimination.



FORM 5: AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO FAMILY & FRIENDS

Name of Patient: _____

DOB: _____

Your privacy is important to us and we want to protect it as much as possible. By signing this form, you authorize Middlesex Hospital Primary Care to disclose information as requested to the individual(s) below.

Name	Relationship to Patient

AUTHORIZATION FOR RELEASE OF INFORMATION:

I acknowledge that my health information, including information regarding diagnosis or treatment of mental illness, drug or alcohol abuse and/or HIV-related information, may be disclosed in accordance with law. I also understand that my health information may be maintained in an electronic health information exchange network or other electronic database, released to and accessible to all providers involved in my care regardless of their location, hospital-affiliation or specialty, and that my Middlesex Health System providers may have access to this information from other providers. I understand that this information may include my prescription history. Finally, I understand that I may be contacted by MHPC or its business associates at the primary phone number that I provided, which may be my cell phone, via phone call and/or text message, for purposes of treatment, appointment reminders and/or payment of my bills.

I specifically authorize the release of any and all information regarding diagnosis or treatment of mental illness, drug or alcohol abuse and/or HIV related information to any person or organization involved in my care or treatment and/or to any organization responsible for payment of services furnished to me. In the event that any of the foregoing information is released, I understand that state and federal law prohibits further disclosure of it without specific written consent of the person to whom it pertains or as otherwise permitted by state and federal law. Withdrawal of this authorization shall be addressed in writing to the Director of Health Information Management at Middlesex Hospital. I understand that neither MHPC nor any of its related entities or providers will condition treatment, payment, enrollment or eligibility for benefits on this authorization to release information.

Signature of Patient or Person granting Authorization on behalf of patient

Date:

Printed Name of Person Signing (If Not the Patient)

Relationship to Patient

FORM 6: MHPC – Pediatric Health History Questionnaire

Name: _____

DOB: _____

Current Concerns / New Problems: No concerns. Establish care with a new Primary Care Provider.

1. _____
2. _____

Past Health History:

Have you had any of the following medical conditions?

- | | | |
|--|--|--|
| <input type="checkbox"/> Acid reflux / Heartburn | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Liver problems |
| <input type="checkbox"/> ADD / ADHD | <input type="checkbox"/> Eczema | <input type="checkbox"/> Migraines / Headaches |
| <input type="checkbox"/> Anemia (low blood count) | <input type="checkbox"/> Feeding difficulties | <input type="checkbox"/> Poor weight gain |
| <input type="checkbox"/> Anxiety / Panic attacks | <input type="checkbox"/> Food allergy / intolerance | <input type="checkbox"/> Premature birth |
| <input type="checkbox"/> Asthma | (Specify: _____) | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Autism Spectrum Disorder | <input type="checkbox"/> Gynecological problems | <input type="checkbox"/> Seasonal Allergies |
| <input type="checkbox"/> Bed wetting | (Specify: _____) | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Blood clotting disorder | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Sexually transmitted infection |
| <input type="checkbox"/> Bone fracture | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Skin condition (Specify: _____) |
| (Location: _____) | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> Cancer (Type: _____) | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Stomach / GI problems |
| <input type="checkbox"/> Concussion / Head injury | <input type="checkbox"/> Irregular heart beat / palpitations | (Specify: _____) |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Substance or alcohol abuse |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Joint problems | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Depression | Specify: _____ | <input type="checkbox"/> Urinary tract infections |
| <input type="checkbox"/> Developmental Delay: Motor | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Developmental Delay: Speech | <input type="checkbox"/> Lead exposure | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Diabetes / High blood sugar | | |

Have you had any of the following surgeries?

- | | | |
|---|---------------------------------------|--|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Circumcision | <input type="checkbox"/> Hernia repair (Type: _____) |
| <input type="checkbox"/> Biopsy (Type: _____) | <input type="checkbox"/> Ear tubes | <input type="checkbox"/> Tonsillectomy |
| | | <input type="checkbox"/> Other: _____ |

Birth and Developmental History:

Location of birth: _____ Type of birth (please check): Vaginal C-Section
 Born within 3 weeks of due date? Yes No If no, at how many weeks? _____
 Birth weight: _____ Birth length: _____ Breastfed: Yes No
 List any complications with pregnancy, delivery, or during newborn period: _____

Prior Hospitalizations: *Please include year and reason*

List Health Care providers involved in your care: *(Example Dr. Jones- Cardiology)*

Allergies: *Please include name of medication or food and type of reaction*

Name	Reaction	Name	Reaction
1)		3)	
2)		4)	

FORM 6: MHPC – Pediatric Health History Questionnaire

Name: _____

DOB: _____

Current Medications: Please include prescription medications, over-the-counter drugs, vitamins and supplements

Name / Dose	# Tabs / Frequency	Name / Dose	# Tabs / Frequency
1)		3)	
2)		4)	

Family History: Please indicate if any of the following conditions are present in your family members

Relative	Status	Cancer (Specify Type)	Diabetes	Heart Disease	High Blood Pressure	Mental Illness (Specify)	Stroke	Other (ex: ADHD, early or unexpected death)
Father	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Paternal Grandfather	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Paternal Grandmother	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Paternal Other _____	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Mother	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Maternal Grandfather	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Maternal Grandmother	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Maternal Other _____	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Siblings _____	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	

Social History:

Who lives in the child's home? _____ Primary caretaker(s): _____

Grade level / School: _____ 504B Education Plan : No Yes

Extracurricular activities/Sports: _____

Interests / hobbies: _____ Job: _____

Parent or Caregiver smokes? No Yes

Smoking: Never Former Smoker Current Smoker (Number of cigs/day: _____)

Alcohol use: Never Tried in the past Current use (Number of drinks/week: _____)

Recreational drugs: Never Tried in the past Current use (What and how often? _____)

Do you exercise regularly? No Yes (What type and how often? _____)

Diet (please check all that apply): Healthy Vegetarian Junk/Fast food Other _____

Environmental Exposures: _____

Have you traveled outside the country in the past 5 years? No Yes (Where? _____)

Concerns for bullying? No Yes (Explain: _____)

Involved with Birth to Three: No Yes (Explain: _____)

Involved with WIC: No Yes

Involved with DCF: No Yes

Name: _____

DOB: _____

Safety/ Injury Prevention: Please indicate if you routinely use or have the following

Safety Measure	Yes	No	Not applicable
Seat belts	<input type="checkbox"/>	<input type="checkbox"/>	
Bike helmet	<input type="checkbox"/>	<input type="checkbox"/>	
Sunscreen	<input type="checkbox"/>	<input type="checkbox"/>	
Smoke detectors	<input type="checkbox"/>	<input type="checkbox"/>	
Carbon monoxide detectors	<input type="checkbox"/>	<input type="checkbox"/>	
Fire extinguisher	<input type="checkbox"/>	<input type="checkbox"/>	
Stair gates / cabinet locks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gated pool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Guns safely secured	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Review of Systems: Please check the corresponding box if you have recently experienced any of the following

GENERAL

- Excessive weight gain
- Lost over 10 pounds
- Fever, chills, night sweats.....

SKIN

- Rashes
- Moles that have changes in appearance

EYES

- Trouble with your vision.....
- Eyeglasses/contact lenses
- Eye pain, redness, excessive tearing

EARS

- Trouble with hearing
- Pain in ear.....
- Discharge (fluid) from ear.....

NOSE/SINUSES

- Trouble with nose/sinuses
- Nosebleeds

MOUTH/THROAT

- Sore throat
- Hoarse voice

NECK

- Swollen glands or lumps.....
- Neck pain or stiffness

BREAST

- Breast lumps or bumps.....
- Pain in the breast

CARDIOVASCULAR

- Chest pain.....
- Racing, pounding heart beat
- Irregular heart beat

RESPIRATORY

- Wheezing.....
- Coughing/ Nighttime coughing.....
- Exposure to someone with TB.....

GASTROINTESTINAL

- Abdominal pain/belly pain
- Nausea/vomiting

Changes in bowel habits.....

Constipation

Diarrhea

GENITOURINARY

Frequent urination

Any pain or burning with urinating.....

MUSCULOSKELETAL

Pain in your joints

Swelling, redness, warmth in joints.....

Back or shoulder pain

NEUROLOGICAL

Dizzy spells or lightheadedness

Any fainting spells.....

Frequent headaches

HEMATOLOGICAL

Bleed or bruise easily.....

ENDOCRINE

Do you ever feel too hot or too cold

Excessive thirst

PSYCHIATRIC

Seen a counselor/therapist or psychiatrist..

Experience mood swings.....

Feel depressed.....

Feel a loss of interest in life

Feel frequently worried or nervous.....

SEXUAL

Sexually active

More than one sexual partner

Not using any contraception

Worried about sexually transmitted

infections.....

Had an unwanted sexual experience.....

FOR BOYS:

Lump on the testicle

Pain in the testicles.....

FOR GIRLS:

Menstrual cycle irregularities

Unusual vaginal discharge or odor

Reviewed by Primary Care Provider: _____

Date: _____