212 PHOENIX COURT, SUITE 1
SEYMOUR, TN 37865
865-577-6475
Fax: 865-577-7942

Thank you for choosing Kids Choice Pediatrics for your family's pediatric care. We strive to provide the best possible medical care for your children and adolescents. Below are our office policies for your review. Any additions or changes to these policies will be posted in our office and on our Facebook page (https://www.facebook.com/KidsChoicePediatrics).

PHYSICIANS: David Enrique Mendez, Medical Doctor and Jill McDowell Newsome, Medical Doctor

BUSINESS HOURS:

Monday through Friday from 8:00AM to 5:00PM
Saturday, Sunday and holidays - Closed
We are closed daily from Noon to 1:00 PM for lunch

APPOINTMENTS:

We are available by appointment only. It is our goal to see sick children on the day of your call. Please call us as early as possible to arrange the appointment.

We recommend routine well child check-ups at:

1, 2, 4, 6, and 9 months of age during the infant's first year of life, then
12, 15, and 18 months of age during the child's second year of life, then
2, 3, 4, and 5 years of age, then
Every 1-2 years for school-age children.

NO-SHOW POLICY: We understand that situations arise in which you must cancel your child's appointment. If you must cancel an appointment, a minimum of 24-hours notice is required. This will enable another patient in need of medical care to be scheduled in that timeslot. Patients who do not show up for their appointment without a call to cancel will be considered a NO-SHOW. Additionally, if you are more than 10 minutes late for a scheduled appointment, you will be asked to re-schedule and this will also be considered a NO-SHOW. Should you incur three (3) NO-SHOWS in a 12 month period, your family will be discharged from the practice.

AFTER-HOURS TRIAGE:

When our office is closed, we have after-hours triage available through East Tennessee Children's Hospital. You may access this service by calling our office number (865-577-6475) and a triage nurse will return your call.

FINANCIAL POLICY:

All co-pays, co-insurance and deductibles are due at the time of service, regardless of who brings the child in for the visit. *****The parent/guardian seeking medical treatment for the child is responsible for any bill incurred, regardless of any divorce decree or court order stating otherwise.***** We gladly accept cash, personal checks or credit card payments from Visa, MasterCard, and Discover. No bills larger than $50 are accepted for co-pays. We must charge a fee, which is posted in our reception area, for any returned checks. In order to file your insurance for you, we need to have a current copy of your insurance card on file. It is your responsibility to inform us of any changes in your insurance. ***We recommend that you verify whether your insurance covers well child visits and immunizations.*** Even though insurance may be filed, all bills are payable upon receipt and the patient/guarantor, not the insurance company, is responsible for the payment of all services. If the balance on your account exceeds 30 days past due, a $15 Late Fee will be assessed to the balance owed. In the event that a past due balance is turned over to our collection agency, the patient/guarantor will be responsible for all fees incurred, including but not limited to, court costs and legal fees. In addition, the family will be discharged from the practice.

Your Check is Welcome!
If your check is returned for non-sufficient funds, you expressly authorize your account to be electronically debited or bank drafted for the amount of the check plus any applicable fees. The use of a check for payment is your acknowledgement and acceptance of this policy and its terms and conditions.

DISCRIMINATION IS AGAINST THE LAW

Kids Choice Pediatrics complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kids Choice Pediatrics does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Kids Choice Pediatrics provides free aids and services to people with disabilities to communicate effectively with us, such as:

- qualified sign language interpreters
- written information in other formats (large print, audio, accessible electronic formats, other formats)

provides free language services to people whose primary language is not English, such as:

- qualified interpreters
- information written in other languages

You can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights

- Electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- By mail at
  U.S. Department of Health and Human Services
  200 Independence Ave. SW
  Room 509F HHH Building
  Washington, DC 20201
- By phone at 1-800-368-1019; 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

INTERPRETER SERVICES

Kids Choice Pediatrics has arranged for language assistance services free of charge. Call (865) 577-6475

ENGLISH
If you speak English, language assistance services, free of charge, are available to you.

SPANISH
Si usted habla español, tiene a su disposición servicios de asistencia con el idioma sin costo alguno.

ARABIC
إذا كنت تتحدث العربية، فستتوفر لك خدمات المساعدة اللغوية مجانًا.

CHINESE
如果您讲汉语普通话，则可以免费向您提供语言协助服务。

VIETNAMESE
Chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị, nếu quý vị nói tiếng Việt.

KOREAN
모국어가 한국어일 경우 무료 언어지원 서비스가 제공됩니다.

FRENCH
Si votre langue est le français, des services d'assistance linguistiques sont mis gratuitement à votre disposition.

LAOTIAN
ຖ້າທ່ານເວົ້າ ພາສາລາວ ການບໍລິການຊ່ວຍເຫຼືອພາສາຟຣີໆຕ້ອງກ່ານ.

AMHARIC
አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ዕርዳታ አገልግሎቶችን፣ በነጻ ያገኛሉ።

GERMAN
Wenn Sie deutsch sprechen, stehen Ihnen kostenlos Sprachhilfen zur Verfügung.

GUJARATI
તમે ગુજરાતી બોલતા હો, તો વિના મૂલ્યે, ભાષા સહાય સેવાઓ તમને ઉપલબ્ધ છે.

JAPANESE
日本語を話される場合には、無償の言語支援サービスがご利用いただけます。

TAGALOG
Kung nagsasalita ka ng Tagalog, may magagamit kang mga serbisyo sa lengguahe na walang bayad.

HINDI
अगर आप हिन्दी बोलते हैं तो भाषा सहायता सेवा निःशुल्क उपलब्ध है।

RUSSIAN
Если ваш язык — русский, то вам могут быть предоставлены бесплатные услуги переводчика.

PERSIAN (FARSI)
اگر شما به فارسی صحبت میکنید، خدمات کمکهای زبان بطور رایگان در دسترس شما می باشند.

TN 10.2016

ATTENTION
SELF-PAY PATIENTS/PARENTS

PAYMENT POLICY

Upon arrival to each appointment, a $50.00 payment will be required before the patient is seen. Once the appointment is completed, we will collect the remaining balance for that day's visit. We offer a 20% discount for services when the full balance is paid on the date of service. If, however, you are unable to pay the balance in full on the date of service, you must speak with our Billing Coordinator before you leave the office to set up a payment plan, which will be based on a percentage of the total family balance (normally 20%). Payment plans are strictly enforced and, if payments are not made on a monthly basis, may result in your account being turned over to a collection agency and your child(ren) being discharged from our practice.

KIDS CHOICE PEDIATRICS
NEW PATIENT INFORMATION

PLEASE COMPLETE ONE FORM PER CHILD.
ALL INFORMATION MUST BE COMPLETE AND ACCURATE.

PATIENT:

Last Name:_____ First Name:_____ MI:_____

_____
Street City County State Zip

Preferred Name:_____

Date of Birth:_____ Sex: M F SSN:_____

Patient Resides with: ○ Both Parents ○ Father ○ Mother ○ Other (specify):_____

Primary Language Spoken: ○ English ○ Spanish ○ Other (specify):_____

Ethnicity (optional): ○ Unknown ○ Hispanic or Latino ○ Not Hispanic or Latino

Race (optional): ○ American Indian or Alaskan Native ○ Asian ○ Black ○ White ○ Hawaiian Native or Pacific Islander

Referred to our practice by:_____

PARENTAL/LEGAL GUARDIAN INFORMATION

BIOLOGICAL MOTHER/LEGAL GUARDIAN #1:

Last Name:_____ First Name:_____ MI:_____

Do you reside with the patient? Y N Date of Birth:_____ Sex: M F SSN:_____

Address:_____
(if not with patient) Street City County State Zip

Home Phone #:_____ Cell #:_____ Work #:_____ Email:_____

Employer Name:_____ Occupation:_____

BIOLOGICAL FATHER/LEGAL GUARDIAN #2:

Last Name:_____ First Name:_____ MI:_____

Do you reside with the patient? Y N Date of Birth:_____ Sex: M F SSN:_____

Address:_____
(if not with patient) Street City County State Zip

Home Phone #:_____ Cell #:_____ Work #:_____ Email:_____

Employer Name:_____ Occupation:_____

Parents' Marital Status: ○ Married ○ Divorced ○ Separated ○ Widowed ○ Single

EMERGENCY CONTACT

(Please list someone outside of the household.)

I hereby authorize Kids Choice Pediatrics to contact the individual listed below in the event of an emergency occurring to my child and/or myself during an on-site medical visit or in the event that I am unable to be reached at the phone number(s) listed above. I understand that, with regards to the emergency situation, this individual may receive test results and/or additional information pertinent to the care and treatment of my child and/or myself.

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

_____ _____ _____

☐ **Check here if you would like the Emergency Contact also included on the CONSENT on the following page.**

CONSENT

I hereby authorize the following individual(s) to bring my child to Kids Choice Pediatrics for medical treatment in my absence. Additionally, the individual(s) listed below may receive test results and additional information pertinent to the care and treatment of my child. This list replaces any previous authorizations and will remain in effect until revoked by me in writing.

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

INSURANCE INFORMATION

Please present Insurance ID card(s) to Receptionist

Who should receive Monthly Patient Account Statements? ◯ **Mother** ◯ **Father** ◯ **Legal Guardian**

Primary: Insurance Carrier:_____ Subscriber /Member ID:_____

Group #:_____ Group Name:_____

Subscriber/Policyholder Name:_____ Sex: M F

DOB:_____ Relationship to Patient:_____

Secondary: Insurance Carrier:_____ Subscriber/Member ID:_____

Group #:_____ Group Name:_____

Subscriber /Policyholder Name:_____ Sex: M F

DOB:_____ Relationship to Patient:_____

FINANCIAL POLICY: All co-pays, co-insurance and deductibles are due at the time of service, regardless of who brings the child in for the visit. *****The parent/guardian seeking medical treatment for the child is responsible for any bill incurred, regardless of any divorce decree or court order stating otherwise.***** We gladly accept cash, personal checks or credit card payments from Visa, MasterCard, and Discover. No bills larger than $50 are accepted for co-pays. We must charge a fee, which is posted in our reception area, for any returned checks. In order to file your insurance for you, we need to have a current copy of your insurance card on file. It is your responsibility to inform us of any changes in your insurance. ***We recommend that you verify whether your insurance covers well child visits and immunizations.*** Even though insurance may be filed, all bills are payable upon receipt and the patient/guarantor, not the insurance company, is responsible for the payment of all services. If the balance on your account exceeds 30 days past due, a $15 Late Fee will be assessed to the balance owed. In the event that a past due balance is turned over to our collection agency, the patient/guarantor will be responsible for all fees incurred, including but not limited to, court costs and legal fees. In addition, the family will be discharged from the practice.

TENNCARE POLICY: Kids Choice Pediatrics is a provider within the BlueCare TennCare network only. We do not accept patients with AmeriGroup, UHC Community or TennCare Select. Should your child(ren)'s coverage change to one of these plans, we will no longer be able to serve as your pediatrician.

NO-SHOW POLICY: We understand that situations arise in which you must cancel your child's appointment. If you must cancel an appointment, a minimum of 24-hours notice is required. This will enable another patient in need of medical care to be scheduled in that timeslot. Patients who do not show up for their appointment without a call to cancel will be considered a NO-SHOW. Additionally, if you are more than 10 minutes late for a scheduled appointment, you will be asked to re-schedule and this will also be considered a NO-SHOW. Should you incur three (3) NO-SHOWS in a 12 month period, your family will be discharged from the practice.

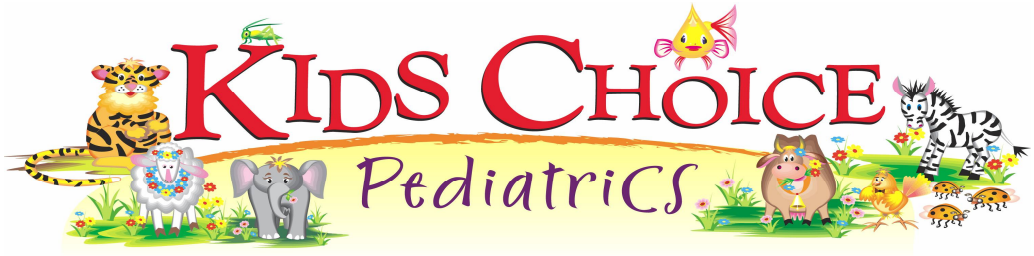
AKNOWLEDGEMENT: *My signature below indicates that, to the best of my knowledge, the information provided is complete and accurate and that I have read and understand the FINANCIAL, TENNCARE and NO-SHOW policies.*

_____ _____

Signature of Person Completing this Form (must be a Parent or Legal Guardian) **Date**

_____ **Relationship to Patient:**_____

Name (Printed)



Patient Authorization for Release of Health Records to External Parties

Date of Request:_____

Records Being Requested For: _____ _____
Patient's Name Patient's DOB

Records Being Requested From: _____
Physician/Practice Name

_____
Address

_____
City State ZIP Code

_____ _____
Phone Fax

I request that the above named patients' medical records be released to:

Kids Choice Pediatrics
212 Phoenix Court, Suite 1
Seymour, TN 37865
PHONE: (865) 577-6475
FAX: (865) 577-7942

I allow the following information to be released (PLEASE CHECK ONE OF THE BOXES BELOW):

- ❑ Entire medical record (including, but not limited to, information regarding medical/health treatment, insurance, demographics, referral documents, and records from other facilities.)
- ❑ Progress notes from _____ to _____
- ❑ Laboratory Reports dated_____
- ❑ Immunization Record only
- ❑ Other:_____

I understand that this consent is good for 1 year and may be revoked at any time by written notice to Kids Choice Pediatrics. This request is for the following reason:

- ❑ New physician
- ❑ Relocation
- ❑ Specialty Consult (i.e. ENT, Surgeon)
- ❑ Dissatisfaction
- ❑ Exchange of information with School
- ❑ Personal Use
- ❑ Other:_____

I understand that once the requested information is sent, additional disclosures may occur and Kids Choice Pediatrics will be held harmless for further disclosures by/to other parties.

Patient/Guardian Signature:_____

Printed Patient/Guardian Name:_____

Relationship to Patient:_____ Date:_____

Witness:_____ Date:_____

KIDS CHOICE PEDIATRICS
Agreement and Consent

Patient's Name (Printed) **Patient's SSN**

Agreement and Consent for Medical Services

Please initial that you have read and understand each of the following statements:

_____I hereby authorize Kids Choice Pediatrics to release medical or other information to referring physicians, the insurance companies, governmental agencies any information requested by such parties, including any information necessary for Kids Choice Pediatrics to obtain payment for their services.

_____I authorize and request that payment be made directly to Kids Choice Pediatrics for any insurance benefits payable for services provided to the patient by Kids Choice Pediatrics. This authorization expressly includes any benefits that are to be provided by TennCare and any other public or private insurance plans. This request will remain in effect until revoked by me in writing.

_____I am the parent or legal guardian of this patient and am authorized to act on his/her behalf. I hereby authorize medical services to be provided to the patient by the physicians and medical staff of Kids Choice Pediatrics.

Agreement for Electronic Transmission of Protected Health Information

Please initial that you have read and understand following statement:

_____Should I request, at any time, that medical information for my child to be sent to me via email, I understand that Kids Choice Pediatrics' email is not encrypted and may, therefore, be at risk of being accessible by unauthorized individuals. By checking the box below, I am acknowledging that I have been made aware of these risks and give my permission for this office to email my child's protected health information to me, at my request, to the email address I have provided below.

☐ I acknowledge that I have been notified of the risk of unencrypted email.

Email address:_____

Please Print Clearly (If we cannot read your email address, we will not send your records.)

Signature of Parent or Legal Guardian **Date**

Relationship to Patient

KIDS CHOICE PEDIATRICS
Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received a copy of Kids Choice Pediatrics' Notice of Privacy Practices, **"Your Information. Your Rights. Our Responsibilities"**.

_____ _____
Patient's Name Patient's Date of Birth

_____ _____
Your Name (Please Print) Relationship to Patient

_____ _____
Signature Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign.

_____ Communication barriers prohibited obtaining the acknowledgement.

_____ An emergency situation prevented us from obtaining acknowledgement.

_____ Other (please specify):

_____

_____

_____ _____
KCP Employee Signature Date

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

We are required by law to maintain the privacy and security of your protected health information.

- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

CHANGES TO THE TERMS OF THIS NOTICE:

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

THIS NOTICE OF PRIVACY PRACTICES APPLIES TO THE FOLLOWING ORGANIZATION:
Kids Choice Pediatrics, LLC

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE OR IF YOU NEED MORE INFORMATION, PLEASE CONTACT OUR PRIVACY OFFICER:

Privacy Officer:	Amber Keeble, Office Manager
Mailing Address:	212 Phoenix Court, Suite 1, Seymour, TN 37865
Telephone:	(865) 577-6475
Fax:	(865) 577-7942
E-mail:	manager@kidschoicepeds.com

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?

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.)

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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.

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