FOR OFFICE USE ONLY: PLEASE CHECK ONE

PEDIATRIC PRIMARY CARE	
PEDIATRIC BEHAVIORAL HEALTH	

NORTHERN NEVADA HOPES *your partner in health.*

PEDIATRIC | Initial Health History

_____

CHILD FIRST NAME MIDDLE NAME LAST NAME

_____

AGE DATE OF BIRTH

If parents are not living together or if child does not live with parents, what is the child's custody status?

_____

_____

Living Arrangements:

☐ Alone ☐ Guardian

☐ Mother ☐ Spouse

☐ Father ☐ Partner/Significant Other

☐ Sibling ☐ Child/Children

☐ Relative ☐ Other/Unrelated

☐ Foster parent

BIRTH HISTORY

Birth weight: _____ lbs _____oz

When was the baby born? ☐ At term ☐ Early ☐ Late

If early, how many weeks gestation? _____ weeks

Did the mother have any illness or problem with her pregnancy? ☐ Yes ☐ No

If yes, please explain: _____

During pregnancy, did the mother:

Smoke? ☐ Yes ☐ No

Drink Alcohol? ☐ Yes ☐ No

Use drugs or medications? ☐ Yes ☐ No

If yes to drugs or medications, what and when? _____

_____

Date of adoption (if applicable): _____

How was the baby delivered? ☐ Vaginal ☐ Cesarean

If cesarean, why? _____

Did the baby have any problems right after birth? ☐ Yes ☐ No

If yes, please explain: _____

How was the initial feeding given? ☐ Breast ☐ Bottle

Did the baby go home with the mother from the hospital? ☐ Yes ☐ No

If no, please explain: _____

GENERAL

Do you consider your child to be in good health? ☐ Yes ☐ No Explain: _____

Does your child have any medical conditions? ☐ Yes ☐ No Explain: _____

Has your child had serious injuries or accidents? ☐ Yes ☐ No Explain: _____

Has your child ever been hospitalized? ☐ Yes ☐ No Explain: _____

Is your child allergic to any medicines or drugs? ☐ Yes ☐ No Explain: _____

Does your child take any medications regularly? ☐ Yes ☐ No Explain: _____

DEVELOPMENT

Name of school or daycare and grade in school: _____

How is his/her behavior in school? _____

Has he/she repeated a grade in school? _____

How is he/she doing in academic subjects? _____

Is he/she in special or resource classes? _____

Are you concerned about your child's physical development? ☐ Yes ☐ No

Explain: _____

Are you concerned about your child's mental or emotional development? ☐ Yes ☐ No

Explain: _____

Are you concerned about your child's attention span? ☐ Yes ☐ No

Explain: _____

FAMILY HISTORY – have any family members had the following:

Deafness	☐ Yes ☐ No	Who: _____	Comments: _____	
Allergies	☐ Yes ☐ No	Who: _____	Comments: _____	
Asthma	☐ Yes ☐ No	Who: _____	Comments: _____	
Tuberculosis	☐ Yes ☐ No	Who: _____	Comments: _____	
Heart disease	☐ Yes ☐ No	Who: _____	Comments: _____	
High blood pressure	☐ Yes ☐ No	Who: _____	Comments: _____	
High cholesterol	☐ Yes ☐ No	Who: _____	Comments: _____	
Anemia	☐ Yes ☐ No	Who: _____	Comments: _____	
Liver/kidney disease	☐ Yes ☐ No	Who: _____	Comments: _____	
Diabetes (before 50)	☐ Yes ☐ No	Who: _____	Comments: _____	
Epilepsy/convulsions	☐ Yes ☐ No	Who: _____	Comments: _____	

Alcohol/Drug abuse	☐ Yes	☐ No	Who: _____	Comments: _____
Mental illness/depression	☐ Yes	☐ No	Who: _____	Comments: _____
Mental retardation	☐ Yes	☐ No	Who: _____	Comments: _____
Immune problems	☐ Yes	☐ No	Who: _____	Comments: _____
HIV/AIDS	☐ Yes	☐ No	Who: _____	Comments: _____
Cancer	☐ Yes	☐ No	Who: _____	Comments: _____
Gastrointestinal problems	☐ Yes	☐ No	Who: _____	Comments: _____

PAST HISTORY – if applicable, does your child have or has he/she ever had:

Frequent ear infections/hearing loss	☐ Yes	☐ No	Explain: _____
Problems with eyes or vision	☐ Yes	☐ No	Explain: _____
Asthma, bronchitis, pneumonia	☐ Yes	☐ No	Explain: _____
Any heart problem or heart murmur	☐ Yes	☐ No	Explain: _____
Anemia or bleeding problem	☐ Yes	☐ No	Explain: _____
Frequent abdominal pain/constipation	☐ Yes	☐ No	Explain: _____
Bladder or kidney infection	☐ Yes	☐ No	Explain: _____
Bed wetting (after 5 years old)	☐ Yes	☐ No	Explain: _____
(F) Has she started her menstrual period?	☐ Yes	☐ No	Explain: _____
Any chronic or recurrent skin problem?	☐ Yes	☐ No	Explain: _____
Frequent headaches?	☐ Yes	☐ No	Explain: _____
Convulsions or neurological problems?	☐ Yes	☐ No	Explain: _____
Diabetes?	☐ Yes	☐ No	Explain: _____
Thyroid or other endocrine problems?	☐ Yes	☐ No	Explain: _____
Alcohol/Drug use?	☐ Yes	☐ No	Explain: _____

Head injuries, concussion, or loss of conciousness?

☐ Yes ☐ No Explain: _____

Any other significant problems? ☐ Yes ☐ No Explain: _____

_____

Patient Consent Form for Electronic Exchange of Individual Health Information

HealtHIE Nevada is a non-profit organization dedicated to connecting the healthcare community to share information electronically and securely to improve the quality of healthcare services. To learn more about the Health Information Exchange (HIE), read the Patient Information brochure. You can ask the doctor that gave you this form for it, or go to the website www.healtHIEnevada.org.

Details about patient information in HealtHIE Nevada and the consent process:

1. **How your information will be used and who can access it:** When you provide consent, only HealtHIE Nevada participants (such as doctors, hospitals, laboratories, radiology centers, and pharmacies), will have access to your health information. It can only be used to:
   - Provide you with medical treatment and related services.
   - Evaluate and improve the quality of medical care provided to all patients, using de-identified health information.
2. **Types of information included and where it comes from:** The information about you comes from organizations that have provided you with medical care, and are HealtHIE Nevada participants. These may include hospitals, physicians, pharmacies, clinical laboratories, and other healthcare organizations. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medications your doctor has prescribed. This may include information created before the date of this Consent Form. This information may relate to sensitive health conditions, including but not limited to:
   - Alcohol or drug use problems
   - HIV/AIDS
   - Birth control and abortion (family planning)
   - Genetic (inherited) diseases or tests
   - Mental health conditions
   - Sexually transmitted diseases
3. **Improper Access or Disclosure of your Information:** Electronic information about you may be disclosed by a participating doctor to others only to the extent permitted by Nevada State Law. If at any time you suspect that someone who should not have seen or received information about you has done so, you should notify your doctor.
4. **Effective Period:** Your consent becomes effective upon signing this form and will remain in effect until the day you revoke it or HealtHIE Nevada ceases to conduct business.
5. **Revoking your consent:** At any time, you may revoke your consent by signing a new consent form and giving it to your doctor. These forms are available at your doctor's office, or by calling 855-484-3443. Changes to your consent status may take 24-48 hours to become active in the system.

Note: Organizations that access your health information through HealtHIE Nevada while your consent is in effect may copy or include your information into their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.

6. **How your information is protected:** Federal and State laws and regulations protect your medical information. HIPAA, the Healthcare Insurance Portability and Accountability Act of 1996, is the federal law that protects your medical records and limits who can look at and receive your health information, including electronic health information. HIPAA's protections were further strengthened by another federal law, the HITECH Act of 2009, which may impose severe financial fines on anyone who violates your medical privacy rights. All health information made available on the HIE, including your medical information, is encrypted to federal standards and is accessible only as allowed by Nevada State law (NRS 439.590). In addition, your doctor must provide you with a Notice of Privacy Practices, which describes how he or she uses and protects your medical information.

Copy of Form: You are entitled to receive a copy of this Consent Form after you sign it.

For Internal Use Only: MRN_____

Patient Consent Form for Electronic Exchange of Individual Health Information

Please read through the consent form and provide the following information: (Please Print)

PATIENT NAME_____
Last *First* *Middle*

PREVIOUS NAME(S)_____ **GENDER:** M____ F____

STREET ADDRESS / P.O. BOX_____

CITY_____ **STATE**_____ **ZIP CODE**_____

PHONE NUMBER _____ **EMAIL**_____

DATE OF BIRTH _____(MM)_____(DD)_____(YYYY)

☐ **Nevada Medicaid Patients Please Read:** Nevada law mandates that "a person who is a recipient of Medicaid or insurance pursuant to the Children's Health Insurance Program may not opt out of having his or her individually identifiable health information disclosed electronically" (NRS 439.539). When a patient is no longer a Medicaid recipient, it is the patient's responsibility to change their consent choice, if they choose to do so. Please sign below to indicate your acknowledgement.

Consent Choices: (CHECK ONE) Nevada Medicaid Patients are exempt from making a selection.
Your choice to give or to deny consent may not be the basis for denial of health services.

☐ **I CONSENT** for all HIE participants to access **ALL** of my electronic health information (including sensitive information) in connection with providing me any health care services, including emergency care.

☐ **I CONSENT ONLY IN CASE OF AN EMERGENCY** for all HIE participants to access **ALL** of my electronic health information (including sensitive information) **ONLY** in the event of a medical emergency.

☐ **I DO NOT CONSENT** for any HIE participants to access **ANY** of my electronic health information **EVEN** in the event of a medical emergency.

_____ _____
Signature of patient or authorized representative Date Time

If I sign this form as the Patient's Authorized Representative, I understand that all references in this form to "I", "me" or "my" refer to the Patient.

_____ _____ _____
Name of Authorized Representative (Printed) Relationship Date Time

_____
Address of authorized representative signing this form (please print):

_____
Phone number of authorized representative

FOR INTERNAL USE ONLY
Name of Organization:_____ Name of Witness:_____
As a witness to this Consent, I attest that the above signer is personally known to me or has established his/her identity with me by satisfactory photo ID, insurance card, or other evidence of identity customarily relied upon in health care.