FOR OFFICE USE ONLY: PLEASE CHECK ONE

PEDIATRIC PRIMARY CARE	
PEDIATRIC BEHAVIORAL HEALTH	

PEDIATRIC | Initial Health History

Today's Date:____________________

____
CHILD FIRST NAME MIDDLE NAME LAST NAME

____
Nickname AGE DATE OF BIRTH

Form completed by: ____

Previous healthcare provider? ____

Specialists (past or present)? ____

Living Arrangements:

Who does the child live with? (ex. Mother, Father, Siblings, Grandparents)

____
____

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

____
____

FAMILY STRESSORS – Please check any stresses in your home or environment:

☐ Job difficulty ☐ Separation/divorce ☐ Domestic Violence ☐ Mental Illness

☐ Drug/alcohol abuse ☐ Incarceration ☐ Difficulty getting enough food

☐ Difficulty with safe, adequate housing

Additional Comments:

____
____

BIRTH HISTORY

Birth weight: ____________ lbs ____________oz Birthplace:_________________________________

When was the baby born? ☐ At term ☐ Early ☐ Late If early, how many weeks gestation? _____________

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? ☐ Yes ☐ No Medications? ☐ Yes ☐ No

If yes to the above, what and when? ____

Date of adoption (if applicable): ____

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 If breastfed, how long?______________________________

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

If no, please explain: ____

Other comments:____

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: ______________________________
Has your child ever had surgery?	☐ 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: ______________________________
Are your child's vaccines up to date?	☐ Yes	☐ No	Explain: ______________________________
Are any family members smokers?	☐ Yes	☐ No	Explain: ______________________________
Are there any guns in the home?	☐ Yes	☐ No	Explain: ______________________________

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: ____________________________________
Nasal allergies	☐ Yes	☐ No	Explain: ____________________________________
Environmental or food allergies	☐ Yes	☐ No	Explain: ____________________________________
Any heart problem or heart murmur	☐ Yes	☐ No	Explain: ____________________________________
Anemia	☐ Yes	☐ No	Explain: ____________________________________
Frequent abdominal pain/constipation	☐ Yes	☐ No	Explain: ____________________________________
Bladder or kidney infection/malformation	☐ Yes	☐ No	Explain: ____________________________________
Bed wetting (after 5 years old)	☐ Yes	☐ No	Explain: ____________________________________
(F) Has she started her menstrual period?	☐ Yes	☐ No	Explain: ____________________________________
(F) Problems with periods	☐ Yes	☐ No	Explain: ____________________________________
Chronic or recurrent skin problem	☐ Yes	☐ No	Explain: ____________________________________
Frequent headaches	☐ Yes	☐ No	Explain: ____________________________________
Congenital cataracts or retinoblastoma	☐ 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/loss of consciousness ☐ Yes ☐ No Explain: ______________________________________
Bleeding or clotting problems ☐ Yes ☐ No Explain: ______________________________________
Blood transfusion ☐ Yes ☐ No Explain: ______________________________________
Chickenpox ☐ Yes ☐ No Explain: ______________________________________
Organ transplant ☐ Yes ☐ No Explain: ______________________________________
Cancer or bone marrow treatment ☐ Yes ☐ No Explain: ______________________________________
Chemotherapy ☐ Yes ☐ No Explain: ______________________________________
Gender transition ☐ Yes ☐ No Explain: ______________________________________
Sexual transmitted infection ☐ Yes ☐ No Explain: ______________________________________
Sleep problems ☐ Yes ☐ No Explain: ______________________________________
Persistent snoring ☐ Yes ☐ No Explain: ______________________________________
Obesity ☐ Yes ☐ No Explain: ______________________________________
Dental decay ☐ Yes ☐ No Explain: ______________________________________
ADHD/anxiety/mood problems/depression ☐ Yes ☐ No Explain: ______________________________________
Developmental delay (physical, social, language, learning)
☐ Yes ☐ No Explain: ____
Any other significant problems?
☐ Yes ☐ No Explain: ____

FAMILY HISTORY – have any family members had the following:

Childhood Hearing Loss ☐ Yes ☐ No Who: _____________________ Comments: _______________________
Nasal Allergies ☐ Yes ☐ No Who: _____________________ Comments: _______________________
Food Allergies ☐ Yes ☐ No Who: _____________________ Comments: _______________________
Asthma ☐ Yes ☐ No Who: _____________________ Comments: _______________________
Tuberculosis ☐ Yes ☐ No Who: _____________________ Comments: _______________________
Heart Disease (before 50) ☐ Yes ☐ No Who: _____________________ Comments: _______________________
Sudden Cardiac Death ☐ Yes ☐ No Who: _____________________ Comments: _______________________
High blood pressure ☐ Yes ☐ No Who: _____________________ Comments: _______________________
High cholesterol ☐ Yes ☐ No Who: _____________________ Comments: _______________________
Anemia ☐ Yes ☐ No Who: _____________________ Comments: _______________________
Kidney disease ☐ Yes ☐ No Who: _____________________ Comments: _______________________
Liver 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: _______________________
Tobacco Use ☐ Yes ☐ No Who: _____________________ Comments: _______________________
Mental illness/depression ☐ Yes ☐ No Who: _____________________ Comments: _______________________
Developmental delay ☐ Yes ☐ No Who: _____________________ Comments: _______________________
ADHD ☐ Yes ☐ No Who: _____________________ Comments: _______________________
Immune problems ☐ Yes ☐ No Who: _____________________ Comments: _______________________
HIV/AIDS ☐ Yes ☐ No Who: _____________________ Comments: _______________________
Cancer (before 55) ☐ Yes ☐ No Who: _____________________ Comments: _______________________
Gastrointestinal problems ☐ Yes ☐ No Who: _____________________ Comments: _______________________
Bleeding Disorder ☐ Yes ☐ No Who: _____________________ Comments: _______________________
Clotting Disorder ☐ Yes ☐ No Who: _____________________ Comments: _______________________
Obesity ☐ Yes ☐ No Who: _____________________ Comments: _______________________

Additional Comments:

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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.