Great Mines
HEALTH CENTER

Past Family and Social History
Under 5 years of age

Date:_____ **Patient Name:**_____ **DOB:**_____ **SEX: □M □F**

Patient Up to Date on Immunizations: Yes or No (Please make sure the office has an updated copy)

If not please state why: _____

Child Social History

Parent Information: *(circle all that apply)*

Parents together	Father Involved	Same Sex Partners
Parents separated	Mother Involved	Foster Care
Lives w/Mother	Father not Involved	Guardian Parents (Clarify):_____
Lives w/Father	Mother not Involved	Other (Clarify): _____

Is the patient adopted □ Yes □ No **Is the patient in foster care □ Yes □ No**

Parents Smoke: *(circle all that apply)* Yes No Outside Only

Pets (What Kind, How Many, Inside or Outside): _____

If age appropriate does your child attend: Daycare Preschool Not Applicable

Name of School/Preschool/Daycare: _____

If none, who cares for your child[ren] during the day: _____

Extracurricular activities: (sports, music, etc.) _____

Has the patient ever received anesthesia □ Yes □ No **Any family history of anesthesia reactions □ Yes □ No**

Does the patient currently have an Epi Pen □ Yes □ No □ Not Applicable

Patient Medical History: Please circle Yes or No, if Yes please provide details

If the patient is adopted or in foster care please include any known medical history below

			Past or Current Diagnosis	Physician Name or Name of Facility
Cancer	No	Yes		
Blood Disorder	No	Yes		
Diabetes	No	Yes		
Endocrine/Metabolic Disorder	No	Yes		
Ear, Nose, & Throat Disorder	No	Yes		
Cardiovascular Disorder	No	Yes		
GI/Stomach Disorder	No	Yes		
GU/Kidney Disease	No	Yes		
Musculoskeletal Disorder	No	Yes		
Neurological Disorder	No	Yes		
Psychiatric/Learning Disorder	No	Yes		
Respiratory/Asthma Disorder	No	Yes		
Skin Disease	No	Yes		
Other Chronic Problems	No	Yes		

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Pregnancy and Birth History:

If the patient is adopted or in foster care please include any known medical history below

Birth Location/Hospital	
Birth Weight	_____ lbs_____ounces
Discharge Weight	_____ lbs_____ounces
Length	_____ cm/inches
Head Circumference	_____ cm/inches
Gestational Age (Full Term or # of weeks)	
Type of Birth (Vaginal or C-section)	
Apgar Scores	
Did the patient have to stay in the NICU	□ **Yes** □ **No** if yes how long _____
Did the patient receive Oxygen while in the hospital	□ **Yes** □ **No** if yes how long _____
Did the patient have jaundice	□ **Yes** □ **No** if yes did the patient require any phototherapy and how long _____
Was patient provided a Synagis Injection while in the hospital	□ **Yes** □ **No** if yes How many_____Date of last injection_____
Did the patient receive a Hepatitis B Vaccine at Birth	□ **Yes** □ **No** if yes date of administration_____
Newborn Hearing Test	□ **Normal** □ **Abnormal** □ **Test Not Performed**
Newborn State Screening	□ **Normal** □ **Abnormal** □ **Test Not Performed**
Any other Newborn Testing Performed	□ **Yes** □ **No** if yes please describe _____
Did the mother have any medical problems during her pregnancy	□ **Yes** □ **No** if yes please describe _____
After discharge, are you aware of any further follow up diagnostic imaging, bloodwork, referrals, or testing that needs to be ordered	□ **Yes** □ **No** if yes please describe _____

MEDICATIONS: **Does the patient currently take any medications □ Yes □ No**

If you marked Yes, please list all prescription and non-prescription medications, vitamins, home remedies, birth control, herbs etc

Medication	Dosage	Directions/ Frequency	Medication	Dosage	Directions/Frequency
1.			**4.**		
2.			**5.**		
3.			**6.**		

HOSPITALIZATONS: **Has the patient ever been hospitalized □ Yes □ No**

If you marked Yes, please list the dates, the name of the hospital, the reason and how long they were there

Date (Month, Day, Year)	**Hospital Name**	**Reason or Diagnosis**	**How long where they there**

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Surgical Procedures: Has the patient had any previous surgeries □ Yes □ No
If you marked Yes, please list the date of the surgery, name of the hospital where it was performed and the name of the procedure

Date (Month, Day, Year)	Hospital Name	Surgical Procedure	Date (Month, Day, Year)	Hospital Name	Surgical Procedure
1.			**3.**		
2.			**4.**		

Allergies: Does the patient have any known allergies □ Yes □ No
If you marked Yes, please list the date they were diagnosed, allergy name and the reaction type

Date (Month, Day, Year)	Allergy Name	Reaction (Ex: anaphylactic shock, rash, diarrhea)	Severity (Ex: Mild, Moderate, Severe)

Does the patient currently have an Epi Pen □ Yes □ No □ Not Applicable

FAMILY HISTORY: Please indicate with a check (√) if the patient's family has had any of the following conditions and then specify in the box their diagnosis. In the second column please indicate their living status. L = Living, D = Deceased, U = Unknown. **If the patient is adopted or in foster care please include any known family medical history below**

	Date of Birth	Living Status	Cancer	Diabetes	Heart Disease	Eye Disorder	Ear Disorder	Respiratory	GI Disorder	GU Disorder	Muscle Disorde	Neurological Disorder	Psychiatric Disorder	Skin Disease
Mother			□	□	□	□	□	□	□	□	□	□	□	□
Father			□	□	□	□	□	□	□	□	□	□	□	□
Sibling			□	□	□	□	□	□	□	□	□	□	□	□
Maternal Grandma			□	□	□	□	□	□	□	□	□	□	□	□
Maternal Grandpa			□	□	□	□	□	□	□	□	□	□	□	□
Paternal Grandma			□	□	□	□	□	□	□	□	□	□	□	□
Paternal Grandpa			□	□	□	□	□	□	□	□	□	□	□	□
Other			□	□	□	□	□	□	□	□	□	□	□	□

Informed Consent for Telehealth Consultation

To serve the needs of people in the community, health care services are now available by interactive video communications and/or by the electronic transmission of information. This may assist in the evaluation, diagnosis, management, and treatment of a number of health care problems. This process is referred to as "telemedicine" or "telehealth." This means that you may be evaluated and treated by a health care provider from a distant location. Since this may be different from the type of consultation with which you are familiar, it is important that you understand and agree to the following statements.

1. I understand that my health care provider recommends that I engage in telehealth consultation ("consulting provider") with Great Mines Health Center.

2. I understand that the consulting provider will be at a different location from me. A health care provider ("presenting provider") may be present with me in the room to assist in the consultation.

3. I understand that I have the option to refuse telehealth service at anytime without affecting my right to future care or treatment and, if applicable, without risking the loss of or withdrawing from my participation in the MO HealthNet program.

4. I understand that there are alternatives to this telehealth consultation. I may have the option to travel to see the consulting provider, or I may refuse to see the consulting provider. Pathways has fully explained the alternatives to me.

5. I understand that I have the right to access my medical history, examinations, x-rays, tests, photographs or other images ("my medical information") related to this consultation.

6. The presenting provider may transmit or share electronically my medical information with the consulting provider who is at a different location. I consent to this transmission, but I can request that my medical information not be sent to the consulting provider if I make the request before my medical information is transmitted.

7. The consulting provider may store or retain my medical information to comply with any applicable state or federal records retention requirements, but may not store or retain my medical information beyond these limits without my written permission.

8. I will be informed if any additional personnel are to be present with me in the room or in the room with the consulting provider. I will give my verbal permission prior to the entry of the additional personnel, and I can exclude anyone from being resent at any time during the consultation.

9. I understand that I have the right to be informed of and to object to the videotaping or other recording of this consultation. I acknowledge that Great Mines Health Center has explained the telehealth consultation in a satisfactory manner and that all questions that I have asked about the consultation have been answered in a manner satisfactory to me or to my representative.

Understanding the above, I consent to the telehealth consultation described above.

_____ _____

Name Date

To recipient of information: This information has been disclosed to you from records whose confidentiality is protected by state and federal law. These laws prohibit you from making any further disclosure of this information without the specific written consent of the person to who it pertains, or as otherwise permitted by law. A general authorization for release of medical or other information may not be sufficient.

Informed Consent for Telehealth Consultation

INFORMED CONSENT FOR DISCLOSURE OF CLIENT INFORMATION FOR BEHAVIORAL HEALTH SERVICES

I, _____, authorize, Great Mines Health Center (Agency to provide treatment) to make disclosure of the specific information listed below in this document to:

_____

(Agency that provided previous treatment)
to:

_____

(Agency that provided previous treatment)

I authorize these agencies to communicate with and disclose to one another information about my symptoms, diagnosis, medications, chemical dependency information, and treatment plan. (May also include information about sexually transmitted disease (STD) testing and treatment, HIV/AIDS testing and treatment, pregnancy testing, prenatal care, birth control, and family planning). This disclosure will be made both verbally and in writing.

I understand that if I do not sign this authorization, I will not be denied treatment; however, I will lose the benefit of my treatment provider knowing about the treatment information from the previous treatment provider.

I understand that my records are protected under federal regulations governing Confidentiality of Alcohol and Other Drug Abuse Patient Records, 42 C.F.R. Part 2, the Health Insurance Portability and Accountability Act (HIPPA), 45 C.F.R. pts. 160 &164, and Wis. Adm. Code section HFS 92.05 and 92.06, and cannot be disclosed without my written consent. I may inspect and receive a copy of any material that is disclosed if I request it. I may revoke this consent at any time with WRITTEN NOTIFICATION, except to the extent that action has been taken in reliance on it.

This authorization for disclosure of information is effective until revoked in Writing

_____

Signature of Patient or Legal Guardian Date

_____

Print Name of Patient or Legal Guardian