Pediatric Past Family and Social History
5 years and up

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

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): _____

Name of School/Preschool/Daycare: _____

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

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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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.**		

HOSPITALIZATIONS: **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**

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.			**4.**		
2.			**5.**		
3.			**6.**		

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

Dental History: Name of Dentist:_____ Date of last exam: _____

Vision History: Name of eye care facility:_____ Date of last exam:_____
Currently wear glasses/contacts: □Yes □No

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Education/School/Social History:

Name of School: _____ **Grade:** _____

School Performance: *(circle all that apply)*

Likes School Dislike School Advanced Program Honor Roll

Excellent Good Grades Grades are declining Struggling to keep up

School Issues/Concerns: *(circle all that apply)*

None Behavior Problems Non Attendance Expelled Suspended

Peer Interactions: *(circle all that apply)*

Makes friends easily Has good group of friends Tends to keep to self Fights with other children

Has trouble making/keeping friends Bullied/picked on by other children Bossy/picks on other children

Extracurricular Activities: *(circle all that apply)*

Baseball/Softball Basketball Soccer Martial arts Dance/cheer Plays musical instrument

Sings in choir Art or drama Scouts Church group Gymnastics Taekwondo Track/Cross Country

Other: _____

Does the patient currently receive any academic assistance at school □ Yes □ No if Yes please provide details

_____

Menstrual History: (Only required for Adolescent girls)

Has the patient started her period □ Yes □ No (if yes please answer the questions below)
What age did the patient start:_____**Is the cycle regular or irregular**: _____
How long does the cycle last:_____**How is the flow (Excessive, Heavy, Minimal)**:_____

Smoking Status: (Only required for patient 13 years and older)

Is the patient a former or current smoker □ Yes □ No (if yes please answer the questions below)
Does or did the patient smoke light, hand-rolled, natural, or herbal cigarettes □ Yes □ No
How many per day or how many packs:_____Age started_____Age stopped _____
Does or did the patient smoke Bidis(flavored cigarettes), Clove cigarettes (Kreteks) □ Yes □ No How many per day or how many packs:_____Age started_____Age stopped _____
Does or did the patient smoke cigars, little cigars, Cigarillos, or Blunts □ Yes □ No
How many per day or how many packs:_____Age started_____Age stopped_____
Does or did the patient smoke a pipe, water pipe or Hookah □ Yes □ No
How many pipes a day:_____Age started_____Age stopped _____
Does or did the patient smoke a Electronic Cigarettes or E-Cigarettes □ Yes □ No
How many per day or how many packs:____Age started___Age stopped _____ **Does or did the patient use Smokeless Tobacco, Chew Tobacco, Snuff, and Snus □ Yes □ No** How many times per day:_____Age started_____Age stopped __

Sexual History: (Only required for Adolescent patient)
Is the patient currently sexual active □ Yes □ No (if yes please answer the questions below) **How many sexual partners have they had:**_____**Do they use protection:** _____
Has the patient ever had an STD (Sexual Transmitted Disease) □ Yes □ No
GIRLS: Is the patient on birth control □ Yes □ No

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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 Disorder	GI Disorder	GU Disorder	Muscle Disorder	Neurological Disorder	Psychiatric Disorder	Skin Disease
Mother			□	□	□	□	□	□	□	□	□	□	□	□
Father			□	□	□	□	□	□	□	□	□	□	□	□
Sibling	[redacted]		□	□	□	□	□	□	□	□	□	□	□	□
Maternal Grandma			□	□	□	□	□	□	□	□	□	□	□	□
Maternal Grandpa			□	□	□	□	□	□	□	□	□	□	□	□
Paternal Grandma			□	□	□	□	□	□	□	□	□	□	□	□
Paternal Grandpa			□	□	□	□	□	□	□	□	□	□	□	□
Maternal Aunt			□	□	□	□	□	□	□	□	□	□	□	□
Maternal Uncle			□	□	□	□	□	□	□	□	□	□	□	□
Paternal Aunt			□	□	□	□	□	□	□	□	□	□	□	□
Paternal Uncle			□	□	□	□	□	□	□	□	□	□	□	□

Please list any other family medical history:

History Completed By: _____

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