

# PHYSICIAN CARE

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Dear patient,

We would like to take this opportunity to thank you for choosing Huntsville Hospital Physician Care for your primary medical care and to welcome you to our office. We are pleased that you have chosen us to provide you with medical services.

Our website ([huntsvillehospital.org/find-a-doctor/huntsville-hospital-physicians-offices](http://huntsvillehospital.org/find-a-doctor/huntsville-hospital-physicians-offices)) should help answer any questions about our office. We want you to know about our office services and what to expect at the time of your first visit.

**Please call our office at the number on the left to schedule your new patient appointment prior to completing the New Patient Forms found on our website. We prefer that you mail, fax or drop off the completed forms prior to your appointment. If unable to do so, please bring the completed forms with you to your appointment. Bring your identification cards, insurance card and medication bottles, as well as your co-payments and/or deductibles the day of your visit.**

We ask that all new patients arrive **30 minutes** prior to your appointment time, so you can be seen by the provider at your scheduled time.

If you are unable to keep your appointment for any reason or if you are going to be **15 minutes** or more late, please call our office as soon as possible. We will be happy to reschedule a more convenient time for you.

Sincerely,



Misty Lyons  
Practice Administrator  
Huntsville Hospital Physician Care at Bailey Cove

9000 Bailey Cove Road  
Huntsville, AL 35802  
o: (256) 428-4900  
f: (256) 428-4912

**Patient**

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Referred by: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ Sex:  M  F

Email address: \_\_\_\_\_

Patient's occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer's address: \_\_\_\_\_ Employer phone: \_\_\_\_\_

Spouse's name: \_\_\_\_\_ Spouse's DOB: \_\_\_\_\_ Spouse's SSN: \_\_\_\_\_

Spouse's occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer's address: \_\_\_\_\_ Employer phone: \_\_\_\_\_

In case of emergency, notify: \_\_\_\_\_ Relationship: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Phone: \_\_\_\_\_

If patient is a minor, list person/s other than emergency contact above who have permission to bring child to office for treatment:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**Insurance** *(provide patient information unless patient is a minor, then provide guarantor's information)*

**PRIMARY INSURANCE**

Insurance name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
Subscriber's name: \_\_\_\_\_ Copay amount: \_\_\_\_\_  
Subscriber ID/Contract Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Subscriber's SSN: \_\_\_\_\_ Subscriber's DOB: \_\_\_\_\_  
Subscriber's Employer: \_\_\_\_\_ Employer's Phone: \_\_\_\_\_

**SECONDARY INSURANCE**

Insurance name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
Subscriber's name: \_\_\_\_\_ Copay amount: \_\_\_\_\_  
Subscriber ID/Contract Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Subscriber's SSN: \_\_\_\_\_ Subscriber's DOB: \_\_\_\_\_  
Subscriber's Employer: \_\_\_\_\_ Employer's Phone: \_\_\_\_\_

Person responsible for this account: \_\_\_\_\_ Phone: \_\_\_\_\_

I agree payment will be made at the time of service. I agree to pay all co0pays, non-covered or routine charges, deductibles and co-insurance amounts that apply. In the event this account is turned over to a collection agency for collection, I will be responsible for all collection fees, court costs and attorney's fees. I authorize HH Physician Care to release information to insurance carriers and for insurance carries to release information to HH Physician Care concerning my illness, treatment and payments (including workmen's compensation) and I hereby assign to the physician all payments for medical services rendered to myself or my dependents if assignment applies.

\_\_\_\_\_  
Signature\_\_\_\_\_  
Date\_\_\_\_\_  
Time

Date: \_\_\_\_\_

Appointment with: \_\_\_\_\_

Name: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_

What other doctors/specialists do you see? Name/Specialty: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

Any new or worsening problems? If yes, please describe: \_\_\_\_\_

## PAST MEDICAL HISTORY *(Please check if you have any of the below.)*

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> AIDS/HIV                   | <input type="checkbox"/> Crohn's Disease          | <input type="checkbox"/> Goiter                | <input type="checkbox"/> Rheumatoid Arthritis     |
| <input type="checkbox"/> Asthma                     | <input type="checkbox"/> Chronic Kidney Disease   | <input type="checkbox"/> Hepatitis A           | <input type="checkbox"/> Seizure Disorder         |
| <input type="checkbox"/> Atrial Fibrillation        | <input type="checkbox"/> Depression               | <input type="checkbox"/> Hepatitis B           | <input type="checkbox"/> Thyroid Nodule           |
| <input type="checkbox"/> Anemia                     | <input type="checkbox"/> Diabetes - Type 1        | <input type="checkbox"/> Hepatitis C           | <input type="checkbox"/> Tuberculosis             |
| <input type="checkbox"/> Anxiety                    | <input type="checkbox"/> Diabetes - Type 2        | <input type="checkbox"/> Infertility           | <input type="checkbox"/> Valvular Heart Disease   |
| <input type="checkbox"/> Autoimmune Disease (Lupus) | <input type="checkbox"/> Diverticulitis           | <input type="checkbox"/> Insomnia              | <input type="checkbox"/> UTI - Recurrent          |
| <input type="checkbox"/> Biliary Cirrhosis          | <input type="checkbox"/> DVT (Blood Clot in Legs) | <input type="checkbox"/> Kidney Stones         | <input type="checkbox"/> Varicose Veins/Phlebitis |
| <input type="checkbox"/> Bipolar Disorder           | <input type="checkbox"/> Eczema                   | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Abnormal Pap Smear       |
| <input type="checkbox"/> Blood Transfusion          | <input type="checkbox"/> GI Bleed                 | <input type="checkbox"/> Lung Cancer           | <input type="checkbox"/> Breast Disease           |
| <input type="checkbox"/> Brain Tumor                | <input type="checkbox"/> GERD (Acid Reflux)       | <input type="checkbox"/> MI (Heart Attack)     | <input type="checkbox"/> Breast Cancer            |
| <input type="checkbox"/> Cirrhosis                  | <input type="checkbox"/> Hemochromatosis          | <input type="checkbox"/> Migraine Headaches    | <input type="checkbox"/> Cervical Cancer          |
| <input type="checkbox"/> CVA/Stroke                 | <input type="checkbox"/> High Blood Pressure      | <input type="checkbox"/> Neurological Disorder | <input type="checkbox"/> Gestational Diabetes     |
| <input type="checkbox"/> COPD (Lung Disease)        | <input type="checkbox"/> High Cholesterol         | <input type="checkbox"/> Osteoarthritis        | <input type="checkbox"/> Rh Sensitized            |
| <input type="checkbox"/> Colon Cancer               | <input type="checkbox"/> Hypothyroidism           | <input type="checkbox"/> Osteoporosis          | <input type="checkbox"/> Sleep Apnea              |
| <input type="checkbox"/> Coronary Heart Disease     | <input type="checkbox"/> Hyperthyroidism          | <input type="checkbox"/> PVD                   | Using a CPAP? Yes / No                            |
| <input type="checkbox"/> PUD (Stomach Ulcers)       |   |  |   |

Other \_\_\_\_\_

## PAST SURGICAL HISTORY

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Amputation                    | <input type="checkbox"/> Cataract Extraction               | <input type="checkbox"/> Kyphoplasty                         | <input type="checkbox"/> Prostate Surgery                    |
| <input type="checkbox"/> AV Fistula Creation           | <input type="checkbox"/> Colon Resection                   | <input type="checkbox"/> Mitral Valve Replaced               | <input type="checkbox"/> Shoulder Surgery<br>Right / Left    |
| <input type="checkbox"/> AV Graft                      | <input type="checkbox"/> Craniotomy                        | <input type="checkbox"/> Nephrectomy<br>Right / Left         | <input type="checkbox"/> Sleep Apnea Surgery                 |
| <input type="checkbox"/> Aortic Valve Replacement      | <input type="checkbox"/> Gastric Bypass                    | <input type="checkbox"/> Pacemaker Implanted                 | <input type="checkbox"/> Thyroid Surgery                     |
| <input type="checkbox"/> Aortic Valve Replaced         | <input type="checkbox"/> Gallbladder Removed               | <input type="checkbox"/> Parathyroidectomy                   | <input type="checkbox"/> Tonsil's Removed                    |
| <input type="checkbox"/> Appendectomy                  | <input type="checkbox"/> Hemorrhoidectomy                  | <input type="checkbox"/> Pneumonectomy<br>Right / Left       | <input type="checkbox"/> Vascular Surgery                    |
| <input type="checkbox"/> Both Legs Bypassed            | <input type="checkbox"/> Hip Replacement<br>Right / Left   | <input type="checkbox"/> PTCA (Angioplasty)                  | <input type="checkbox"/> Breast Augmentation<br>Right / Left |
| <input type="checkbox"/> Back Surgery                  | <input type="checkbox"/> Invasive Pain Procedure           | <input type="checkbox"/> Rotator Cuff Repair<br>Right / Left | <input type="checkbox"/> Mastectomy<br>Right / Left          |
| <input type="checkbox"/> Bronchoscopy (Lung Scope)     | <input type="checkbox"/> Kidney Transplant<br>Right / Left | <input type="checkbox"/> Abdominal Hysterectomy              | <input type="checkbox"/> Lumpectomy<br>Right / Left          |
| <input type="checkbox"/> CABG (Heart Bypass)           | <input type="checkbox"/> Knee Arthroscopy<br>Right / Left  | <input type="checkbox"/> Ovaries Removed<br>Yes / No         |  |
| <input type="checkbox"/> Carotid Endarterectomy        | <input type="checkbox"/> Knee Replacement<br>Right / Left  |  |  |
| <input type="checkbox"/> Carpal Tunnel<br>Right / Left |  |  |  |

Other \_\_\_\_\_

Patient name: \_\_\_\_\_

DOB \_\_\_\_\_

**FAMILY HISTORY**

	Father	Mother	Brother	Sister	Children
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Artery Disease/Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease (Chronic)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer (Type)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**SOCIAL HISTORY** (Check or circle appropriate)

Married     Single     Divorced     Widowed

Work  Part-Time     Full-Time     Retired     Disabled    Occupation: \_\_\_\_\_

Children: Yes / No    Religious Affiliation \_\_\_\_\_

**ALLERGIES OR MEDICATION REACTIONS**

**NO KNOWN DRUG ALLERGIES**

Allergic to: \_\_\_\_\_

Reaction: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**RISK FACTORS** (Check or circle appropriate)

Current tobacco use    Year started \_\_\_\_\_  
 Type of tobacco: Cigarettes / Cigars / Snuff / Vapor

Former tobacco use    Year quit \_\_\_\_\_

Never smoked  
 Second hand smoke    Yes / No

Do you wear a seat belt?    Yes / No

Multiple sexual partners?    Yes / No

Caffeine Use    Yes / No

How many drinks per day \_\_\_\_\_

Alcohol use    Yes / No

How many per day? \_\_\_\_\_    Type \_\_\_\_\_

Exercise    Yes / No

Times per week \_\_\_\_\_    Type \_\_\_\_\_

**CURRENT MEDICATIONS**

**REFER TO LIST**

**REFER TO BOTTLES**

Please include the dose and how often you take the medication. (Skip if you brought a list or bottles)

Name	Dosage	How many times per day?	As Needed (PRN)

Pharmacy \_\_\_\_\_ Phone# \_\_\_\_\_ Location \_\_\_\_\_

Do we have permission to receive medication history on patient via electronic prescription? Yes / No

Signature of patient/guardian \_\_\_\_\_ Date \_\_\_\_\_

Patient name: \_\_\_\_\_

DOB \_\_\_\_\_

**MEDICAL PROBLEMS** Have you had any recent or persistent problems with the following?

**General**

- Weight Gain/Loss
- Fever/Chills/Fatigue
- Snoring
- Sleep Troubles
- Depression/Anxiety

**Neuro**

- Headache
- Head injury
- Blackouts/Dizzy
- Seizures/Tremors
- Memory Loss
- Numbness/Tingling
- Forgetfulness/  
Confusion
- Abnormal Coordination

**Urinary**

- Frequency
- Trouble starting or  
stopping urine stream
- Blood In Urine
- Painful Urination
- Urinating at Night
- Urine Leakage
- Unable to Urinate

**ENT**

- Allergies
- Sinus Congestion
- Glasses/Contacts
- Blurred Vision
- Ringing
- Hoarseness
- Runny Nose
- Hearing Loss
- Trouble Swallowing
- Neck Lump
- Swollen Glands
- Earache

**Skin**

- Rashes
- Abnormal moles
- Changes in Hair/  
Hair Loss
- Wounds that will  
not heal

**Heart**

- Chest Pain
- Palpitations
- Shortness of Breath
- Ankle Swelling

**Lungs**

- Persistent Cough
- Cough Up Blood
- Shortness of  
Breath
- Wheezing

**Women**

- Irregular Periods
- Pelvic Pain
- Nipple Discharge
- Lumps In Breasts
- Frequent Sweats/  
Hot Flashes
- Vaginal Discharge

**Musculoskeletal**

- Joint Pain
- Gout
- Varicose Veins
- Leg Swelling
- Back Pain
- Joint Stiffness
- Muscle Weakness
- Muscle Pain
- Muscle Cramps

**Gastrointestinal**

- Reflux/GERD
- Vomiting
- Diarrhea
- Constipation
- Bloody/Black Stool
- Hemorrhoids
- Loss of Appetite
- Rectal Bleeding
- Abdominal Pain

**Sexual**

- Problems with sex
- Erectile Dysfunction
- Painful Intercourse
- Decreased Sexual  
Desire
- Blood in Semen

**Endocrine**

- Excessive Thirst
- Excessive Urination
- High Blood Sugars
- Heat Intolerance
- Cold Intolerance

Please enter the most recent date and results of the following:

	<b>Date</b>	<b>Results</b>	<b>Performed by (who/where)</b>
Colonoscopy	_____	_____	_____
Pap Smear	_____	_____	_____
Mammogram	_____	_____	_____
Bone Density Scan	_____	_____	_____
Menstrual Period	_____	_____	_____
PSA (Prostate Scéen)	_____	_____	_____
Eye Exam	_____	_____	_____

When was your last vaccine on the following:

	<b>Date</b>	<b>Would you like one?</b>
Flu Vaccine	_____	Yes / No
Tetanus Vaccine	_____	Yes / No
Pneumonia Vaccine	_____	Yes / No
Shingles Vaccine	_____	Yes / No

Patient Name: \_\_\_\_\_ SSN (opt): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Date of Service: \_\_\_\_\_

Chart #: \_\_\_\_\_

Provider: \_\_\_\_\_

**I authorize the use or disclosure of the above named individual's health information as described below:**

- Huntsville Hospital Physician Network is authorized to make the disclosure.
- The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)
  - All/entire record
  - Consultation report
  - Visit/encounter notes
  - Operative report
  - Laboratory results
  - Immunization record
  - X-ray and imaging reports
  - Drug and alcohol treatment
  - Problem list
  - HIV/AIDS/STD treatment
  - Medication list
  - Registration record
  - Allergies list
  - Other: \_\_\_\_\_
  - EKG report
  - Pathology report
- I understand the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndroms (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.
- This information may be disclosed to and used by the following individual or agency:

**Records release format:**

(choose one)

- e-delivery  
(HealthPort connect)
- CD
- Paper

Name: \_\_\_\_\_ Address: \_\_\_\_\_

for the purpose of: \_\_\_\_\_

- I understand that I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Record Department. I understand the revocation will not apply to information already released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- Unless otherwise revoked, the authorization will expire on the following date, event or condition:

\_\_\_\_\_  
If left blank, this authorization will expire six months from the date of signing.

- I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations.
- I understand as the recipient, I am responsible for the security of these medical record copies and the health information contained therein, whether in paper format or on CD/DVD.
- I understand I need not sign this form in order to ensure health care treatment, payment, enrollment in my health plan or eligibility for benefits. HOWEVER, I understand that if I refuse to sign this form, under specific conditions the organization can refuse treatment enrollment in the health plan and/or eligibility for benefits.

\_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_\_\_\_\_\_  
Relationship to patient (if signed by legal representative)\_\_\_\_\_  
Signature of witness \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_OFFICE USE ONLY: Any portion of the record request found in paper chart?  Yes  No

Name of Organization/Person \_\_\_\_\_

Address \_\_\_\_\_

Fax/Phone \_\_\_\_\_

**Huntsville Hospital requests information for the following patient:**

Patient Name \_\_\_\_\_

SS# (Optional) \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Signature \_\_\_\_\_ Date of Service \_\_\_\_\_

Patient Number: \_\_\_\_\_

**Requested information for treatment, payment or operations:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Discharge summary    | <input type="checkbox"/> EKG report         | <input type="checkbox"/> Emergency dept record |
| <input type="checkbox"/> History and physical | <input type="checkbox"/> Nurses' notes      | <input type="checkbox"/> Laboratory results    |
| <input type="checkbox"/> Operative note       | <input type="checkbox"/> Progress notes     | <input type="checkbox"/> Imaging results       |
| <input type="checkbox"/> Pathology report     | <input type="checkbox"/> Physicians' orders | <input type="checkbox"/> Other: _____          |
| <input type="checkbox"/> Consultation report  | <input type="checkbox"/> Outpatient record  |  |

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please send to:

**Airport Road**  
Fax: (256) 265-0777

**Fayetteville**  
Fax: (931) 438-0069

**Madison, Hwy 72**  
Fax: (256) 265-5647

**Bailey Cove**  
Fax: (256) 428-4912

**Hampton Cove**  
Fax: (256) 265-0357

**Madison, Lanier Rd.**  
Fax: (256) 265-5971

**Elkton**  
Fax: (931) 468-2103

**Lowell Drive**  
Fax: (256) 265-9875

**Hazel Green Pediatrics**  
Fax: (256) 828-0526

Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Witness \_\_\_\_\_



**Patient information**

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Date: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

Referred by: \_\_\_\_\_ Previous family physician: \_\_\_\_\_

**IT IS THE RESPONSIBILITY OF THE PARENTS TO PROVIDE A COPY OF THE IMMUNIZATION RECORD.**Name/s and relationship/s of those living with the child:  
\_\_\_\_\_  
\_\_\_\_\_

Legal guardian of the child: \_\_\_\_\_

Please list the name/s of those who are authorized to bring the child in for medical exams, including immunizations:  
\_\_\_\_\_  
\_\_\_\_\_Name/s and phone number/s of those we may discuss the patient's medical history with (phone and/or office visits):  
\_\_\_\_\_  
\_\_\_\_\_The child's parents are:  Married  Divorced  Separated  Unmarried  WidowedIs there any legal reason why we cannot discuss the child's medical care with either parent?  
\_\_\_\_\_  
\_\_\_\_\_**Education/Development/Social**Does the child attend daycare?  No  Yes

What school does the child attend? \_\_\_\_\_ Grade: \_\_\_\_\_

(If homeschooled, please list)

Does the child receive any special services such as physical therapy, speech therapy, occupational therapy or special education?

 No  Yes: \_\_\_\_\_

Does the child have any behavioral, social or learning problems?

 No  Yes: \_\_\_\_\_

Does the child participate in organized sports or hobbies?

 No  Yes: \_\_\_\_\_Are there any smokers in the house?  No  Yes**Family history**

Check any that the child has a family history of from the following:

- |  |   |
|--|---|
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Seizures   |
| <input type="checkbox"/> High blood pressure     | <input type="checkbox"/> Sickle Cell Anemia                               |
| <input type="checkbox"/> Childhood heart disease | <input type="checkbox"/> Birth defects                                    |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Sudden death                                     |
| <input type="checkbox"/> Allergies               | <input type="checkbox"/> Other pertinent family medical history:<br>_____ |
| <input type="checkbox"/> Learning problems       |   |

**Medical history**

Please list the child's medical problem and check all that apply.

 Asthma  Allergic Rhinitis  Attention Deficit Disorder (ADD)  Migraines  Seizures  Heart Murmur  
\_\_\_\_\_



Has the child ever been hospitalized? If so, when for what?

No  Yes: \_\_\_\_\_

Has the child ever had any surgeries? Check all that apply.

None  Appendectomy  Tonsillectomy  Adenoidectomy  Tubes in ears  Gall Bladder

Orthopedic  Other: \_\_\_\_\_

What medications does the child take?

\_\_\_\_\_  
\_\_\_\_\_

Does the child have any medication allergies?

No  Yes, list: \_\_\_\_\_

Reaction: \_\_\_\_\_

What specific health concerns do you wish to address today?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any concern about your safety or the child's safety?  No  Yes

### For teen girls

Have you started your period?  No  Yes, at age: \_\_\_\_\_ Are your period every month?  No  Yes

How long do they last? \_\_\_\_\_ Are they painful?  No  Yes

Have you ever been pregnant?  No  Yes

### For teen boys and girls

Do you: smoke?  No  Yes Drink alcohol?  No  Yes Use illicit drugs?  No  Yes

Are you sexually active?  No  Yes - do you practice "safe" sex?  No  Yes

Have you ever had a child?  No  Yes

What are your long term goals for the future?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What talents do you have which give you joy and a sense of accomplishment?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Dietary history (all ages)

Please list everything the child has eaten or drunk in the last 24 hours:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of person completing this form: \_\_\_\_\_ Relationship: \_\_\_\_\_