1411 N. Beckley Avenue, Suite 164
Dallas, TX 75203
**Donza J. Rogers, MD**

## Patient Registration Form

Patient 1_____ Sex ___ Date of Birth _____
Patient 2_____ Sex ___ Date of Birth _____
Patient 3_____ Sex ___ Date of Birth _____
Patient 4_____ Sex ___ Date of Birth _____
Patient 5_____ Sex ___ Date of Birth _____

## PLEASE PROVIDE *BOTH* PARENTS/GUARDIAN INFORMATION WITH THE POLICY HOLDER FIRST:

### Policy Holder's Information

Name_____
Relation to child _____
Date of Birth _____
SS# _____
Address_____
City/State/Zip_____
Home Phone _____
Cell Phone _____
Employer_____
Work Phone_____
Email _____

### Other Parent's Information

Name_____
Relation to child _____
Date of Birth _____
SS# _____
Address_____
City/State/Zip_____
Home Phone _____
Cell Phone _____
Employer_____
Work Phone _____
Email _____

Nearest relative not living at same address_____Phone_____

☐ Please check the box if nearest relative can receive information from Kessler Pediatrics in regards to patient(s).

### Insurance Information

(P) Insurance Co._____Policy #_____Group# _____
(S) Insurance Co._____Policy #_____Group# _____

### Authorization of Treatment and Assignment of Benefits

I authorize the Pediatricians of Kessler Pediatrics to treat my child. I have been presented with a copy of the Notice of Privacy Practice detailing how my child's health information may be used and disclosed as permitted under federal and state law and outlining my rights regarding my child's health information. I also acknowledge I have been presented with a copy of Kessler Pediatrics Office Policies.

Signature of parent or legal guardian_____
Relation to Child_____Date_____

Revised: 01/2018

# Authorization to disclose Health Information

**I hereby authorize the use or disclosure of information from the medical record of patient:**

**Patient Name**_____ **Date of Birth**_____

| **To / From (circle one)** | **To / From (circle one)** |
|---|---|
| **Kessler Pediatrics** | **Organization** _____ |
| **1411 N. Beckley Ave, Suite 164** | **Address** _____ |
| **Dallas, TX 75203** | _____ |
| **(214) 941-6691 (office)** | **Phone** _____ |
| **(214) 941-0437 (fax)** | **Fax** _____ |

**Please release the following:**

**___ Entire Record (including Labs, X-rays etc.) OR**

**_____ Newborn Hospital Assessment Record**
**_____ Immunization Record Only**
**_____ Most recent Office Notes**

**Purpose for the Release:**

**_____ Continuity of Medical Care _____ Transferring Primary Care Physicians _____ Legal Purposes**

By signing below, you hereby consent for **Kessler Pediatrics** to use and/or disclose information about yourself (or another person for whom you have authority to sign) that is protected under federal law, for the sole purposes to treatment, payment, and heath care operations. You may refuse to sign this consent form.

You should read the **Notice of Privacy Practices** for **Protected Health Information** attached to this form before signing the consent. The terms of the Notice may change from time to time, and you may request a revised copy by asking the Privacy Office at **Kessler Pediatrics.**

You have the right to request that **Kessler Pediatrics** restrict how **Protected Health Information** is used or disclosed to carry out treatment, payment, or health operations. **Kessler Pediatrics** is not required to agree to requested restrictions; however, if Kessler Pediatrics agrees to your requested restriction, the restriction is binding on it.

Information about you is protected under federal law, and you have the right to revoke this consent, unless we have taken action in reliance on your authorization (as determined by our Privacy Officer). By signing below, you recognized that the **Protected Health Information** used or disclosed pursuant to this consent may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

You may communicate with the following individual(s) regarding my child's condition or course of treatment:
_____.

You may communicate confidential information to me, including invoices for services, to the following address and/or phone/fax numbers:_____.

_____ Date_____

Signature of patient or Legal Representative

_____ _____

Relationship to Patient Witness

# Kessler Pediatrics Office Policies

**(revised January 2018)**

***Welcome to Kessler Pediatrics. We are extremely pleased you have chosen us to provide pediatric care for your child and strive to make your experience with our office a pleasant one. We look forward to having a long relationship with you and your family.***
***This sheet will provide a general overview of our office policies. Please read carefully. We are happy to answer any questions you may have regarding our policies.***

## Office Hours

Our office is open for patient care Monday through Friday from 9 a.m. to 4 p.m. We are closed for lunch from 1-2 p.m. daily.

## After Hours

We are available to assist you during our regular office hours and encourage you to call with questions during our opening hours. For questions that arise when our office is closed, we are pleased to provide you with access to our nurse triage after-hours phone line. A physician is always on call to provide backup for any issues that cannot be handled by our nurses. The after-hours number is **855-456-6976**.

## Scheduling Appointments

Our receptionists are available beginning at 8:30 am Monday through Friday to schedule appointments. Patients are seen ***by appointment only***. We are not a walk-in clinic and strongly discourage patients from walking into our office to obtain an appointment. Walk-ins will not be seen on an immediate basis and will be given the next available appointment time. Life threatening emergencies require EMS notification via 911.

**Well-Child checkups** are essential in ensuring the proper health and development of your children. Patients should be seen at newborn, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, and 2 years. After 2 years of age, patients should be seen annually for an exam. We recommend scheduling well child exams 1-2 months in advance as these appointments book quickly. We do not automatically schedule well appointments for patients. It is the responsibility of the patient to schedule their well exams. Due to the length of well child exams, we will not be able to perform a well child exam during a sick visit as the time allotted for a sick visit is much shorter than a well exam. ADHD evaluations should ideally be scheduled at least 2 months in advance.

**Same day sick visits** are scheduled on a **first-come, first-serve basis**. If our schedule fills for the day, we may not be able to honor all patient requests for a same day sick appointment. If we are unable to schedule a same day sick appointment, we will be sure to schedule an appointment for the next day. We will always do our best to get our sick patients seen as quickly as our schedule permits.

## Late Arrival Policy

We value your time and will make every attempt to see your child in a timely fashion. Please extend us the same courtesy and be on time for your appointment. If you are running late for your appointment, please notify our office, and we will attempt to make accommodations within our schedule. Patients who are more than **fifteen (15) minutes late** for their appointment will be rescheduled for the next available time slot. Please be advised that although we will try to accommodate you on the same day, occasionally the next available appointment will not be on the same day of your originally scheduled appointment.

## No Show Policy

We are sensitive to unexpected emergencies, which may prevent you from keeping your appointments. However, we ask that you extend us the courtesy of notifying the office when you are unable to make your appointment. This notification allows us to offer your time slot to another patient who needs to be seen. Failure to cancel or reschedule your appointment **prior** to your scheduled time will result in a fee of **$75**.

## Prescription/Referral Requests

Prescription refills and specialist referrals may be made during office hours and will only be provided to patients who have had a well-child exam within the last year. Requests for prescription refills may be called in directly to our office or faxed from your pharmacy. When contacting our office for prescription refills, please have the name and dosage of the medication as well as the name and phone number of your pharmacy readily available. Please allow up to **three (3) days** for prescription refills to be processed. Refills on **ADHD medications** will be provided for patients who have been seen within the last three months for their ADHD evaluation or follow-up. These prescription requests may take up to **three (3) days** and cannot be called into a pharmacy. These prescriptions must be picked up in our office.

Our office requires that you contact us for referrals prior to your appointment with a specialist. Please allow up to **seven (7) days** for the referral process to be completed. We will not process last minute, same day requests for specialist referrals. Additionally, we will not back date referrals. Be sure to discuss with your insurance company whether or not you will need a referral for the specialist visit prior to the office visit. When contacting our office for a referral request, please have all pertinent information for the referral to be processed. Information needed for your referral includes but is not limited to the Physician's name, Office Location, Office Phone Number, Physician's NPI number, and Date of Visit. Your insurance company may require additional information. We will not be able to process your referral without all needed information. It is your responsibility to provide us with the necessary information to process your requested referral. The referral will be faxed to the specialist once it has been processed. We are under legal obligation to all insurance companies to process referrals according to Texas State Law.

## Medical Forms and Immunization Records

Requests for medical records must be made in writing and contain the signature of a parent or guardian. Medical records requested for personal use will incur a charge of $25 for the first 20 pages and $0.50 for each additional page. There is no charge to send medical records to another physician. Immunizations records are provided at no charge for the first copy and $10 for any additional copies. FMLA forms will be completed at a charge of $30. School and camp physicals are completed free of charge for any patient who has had a well child exam within the last year. Please allow up to **seven (7) business days** for the completion of any requests for forms or medical/immunization records.

## Financial Policy

Kessler Pediatrics participates with most private insurance companies. We do not currently participate in any Medical Assistance programs, i.e. Medicaid. If you plan to use your insurance for your office visit, please have your insurance card with you at the time of your visit. Be aware that all HMO plans and many Choice plans require that a PCP be selected for the plan. To ensure accurate billing and payment, please be sure to contact your insurance company and select Dr. Donza Rogers as your child's PCP. Failure to select Dr. Rogers as your PCP may result in higher co-pay fees and decreased reimbursement from your insurance company. Depending on your insurance plan, you may have a co-**pay, co-insurance, or a deductible** due at the time of your visit. A Co-**pay** is a set dollar amount that your insurance company requires you to pay at the time of each visit. A Co-**insurance** is an amount required by some insurance carriers that is above the deductible and co-pay amounts. A **Deductible** is a set amount your insurance company requires you to pay towards your health care costs before your insurance begins paying toward your services. Questions regarding your co-pay, co-insurance, and deductible should be directed to your insurance company. Co-pays, Co-insurance, and Deductible amounts are due at the time services are rendered. Your insurance company contractually requires these payments, and we cannot bill these payments. If you refuse to pay your required amount at the time of service, you may be denied care for that date of service. If you will not be utilizing insurance for your visit, you are required to pay the associated fees for your visit at the time of service. Please see our fee schedule for our current office fees. Account balances that you may have incurred from prior or present dates of service will be collected at each visit unless prior arrangements have been made with the office manager.

### Account Balances and Collections

Kessler Pediatrics will make every effort to assist you in keeping your account current with our office. As a courtesy to you, we will file claims with your insurance to obtain payment. However, please remember that you are ultimately responsible for all charges associated with the services we provide to you. We will send you a monthly statement reflecting balances on your account for which you are responsible. Patient balances are expected to be paid in full upon receipt of the statement. A finance charge will be applied each month a statement is re-sent for payment. If you are unable to pay your balance, please contact our office manager immediately to determine if we can arrange a payment schedule to keep your account current. We reserve the right to refuse care to any patients who refuse to pay their balance and/or make payment arrangements with our office. Failure to pay account balances older than six (6) months may result in us turning your account over to a collections agency for payment. Failure to pay account balances older than one (1) year may result in dismissal from our practice.

## Cell Phone Etiquette

Please do not use your cell phone when approaching the front desk or upon entering the exam rooms. Cell phones can be very disruptive to the flow of patient care.

## School/Work Excuses

We are only able to provide school and work excuses for patients and/or parents who are seen within our office. At the end of each office visit, you will be provided with an excuse noting the day that you were seen and the date most appropriate for you to return to school or work. Please do not ask our office to excuse missed days outside of these guidelines.

### Separated/Divorced Families

For families in which the parents are either separated and/or divorced, the parent bringing the child to the office is authorizing treatment and is, therefore, the parent responsible for payment on the date of service. We will not call or contact the other parent to obtain payment information. Please have the child's payment and insurance information with you when arriving for your office visit. All fees associated with the visit, including but not limited to the co-pay of the child's insurance plan, are due at the time services are rendered. Additionally, all account balances and charges deemed parent responsibility by the contracted insurance plan are due to Kessler Pediatrics by the parent presenting the child for the date of service and authorizing treatment.

If there is a divorce decree requiring the other parent to pay a portion or all of the treatment costs incurred, it is the responsibility of the authorizing parent to collect from the other parent. Kessler Pediatrics will not make special provisions or act as a mediator in collection of payment. We can provide a copy of the claim or receipt of charges to the authorizing parent at each visit upon request to assist in collection of fees from the other parent.

Non-compliance with this policy may result in termination of care.

KESSLER Pediatrics

**Patient Agreement**

I acknowledge that I have read and understand the policies and procedures of Kessler Pediatrics as outlined in this document. I agree to adhere to the specific policies of Kessler Pediatrics. I am aware that if I do not comply with above stated guidelines, Kessler Pediatrics reserves the right to terminate care with the office.

Parent Name: _____

Signature: _____

Patient Name: _____

Date: _____

KESSLER Pediatrics

**Donza J. Rogers, MD**
**1411 N. Beckley Avenue, Suite 164**
**Dallas, Texas 75203**

# Insurance Liability Notice

## Physician Statement

In many cases, your insurance company will limit payment of a service due to limitations of your policy. If your insurance company does not pay for a service due to policy limitation, you are financially responsible for the payment of that service.

## Beneficiary Agreement

I understand that in some cases, certain services will be denied payment from my insurance company due to limitations of my personal policy. In the case that my insurance company denies payment for this service, I understand that I am fully responsible for the payment of this service.

Signed: _____

Date: _____

# NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), all medical records and other individually identifiable health information of which we have knowledge must be kept confidential. All personal health information used by us or disclosed by us is covered by this Act regardless of whether this personal health information is in electronic, oral or paper form. Several new rights are granted to patients under this Act, allowing control over how your personal health information is used, how you can access it, and in some cases amend it.

We are required by law to maintain the privacy of your personal health information and to provide you with notice of our legal duties and privacy practices with respect to your personal health information.

We may be assessed a penalty for any misuse or unauthorized disclosures of your personal health information as regulated by HIPAA.

This Notice of Privacy Practices is effective on **April 14, 2003**.

We are bound to abide by the terms of this notice and reserve the right to make revisions to this policy. Should revisions be made, you will be notified in writing, and a copy of the revised policy will be made available at your request.

You will be asked to sign a consent form authorizing us to use and disclose your personal health information only for the following purposes, as defined under the Act:

- Treatment means the provision, coordination, or management of health care and related services by one or more healthcare providers, including the coordination or management of health care by a healthcare provider with a third party; consultation between healthcare providers relating to a patient; or the referral of a patient for health care from one healthcare provider to another. An example of this would be a dentist referral to an orthodontist.
- Payment means obtaining reimbursement for the provision of health care; determinations of eligibility or coverage; billing; claims management; collection activities; justification of charges; and disclosure to consumer reporting agencies; protected health information relating to the collection of reimbursements (only certain information may be disclosed). An example of this would be submitting your bill for health care services to your insurance company.
- Health care operations are any activity related to covered functions in which we participate in the function of our offices, such as conducting quality assessment activities; protocol development; case management and care coordination; auditing functions; business management and general administrative activities, including implementation of this regulation; customer service evaluations; resolution of grievances; fundraising; and marketing for which an authorization is not required. An example of this would be evaluation customer service given to patients.

We may, without prior consent use or disclose your personal health information to carry out treatment, payment or health care operations:

- Directly to you at your request;
- In an emergency treatment situation, if we attempt to obtain such consent as soon as reasonably practicable after the delivery of such treatment, if we are required by law to treat you and attempts to obtain consent are unsuccessful, or if we attempt to obtain consent but are unable, due to barriers of communication, but we determine in our professional opinion that treatment is clearly inferred from the circumstances;
- Pursuant to and in compliance with an authorization signed by you; and
- Provided that you are informed in advance of the use and disclosure and have the opportunity to agree to or prohibit or restrict the use or disclosure. This may be an oral agreement between us and may include a directory maintained at our facility containing specific information allowed by this Act.

We may de-identify your personal health information by using codes or removing all individually identifiable health information.

All other uses and disclosures will be made only upon securing a written authorization form signed by you. You have the right to revoke this authorization, at any time, upon written notice and we will abide by that request. However, exception would be any actions already taken, relying on your authorization, prior to revocation notice.

We may contact you to provide appointment reminders, or to inform you about treatment alternatives or other health related benefits or services that may be of interest to you. We may also contact you for fundraising purposes.

Under HIPAA, you have the following rights with respect to your protected health information:

- You have the right to request restrictions on certain uses and disclosures of protected health information, including restrictions placed upon disclosure to family members, close personal friends, or any other person you may identify. We are, however, not required to agree with a requested restriction;
- You have the right to receive confidential communications of your protected health information, either directly from us or from us or by alternative means or from alternative locations;
- You have the right to inspect and copy your protected health information;
- You have the right to amend protected health information, however, this request may be denied under certain circumstances;
- You have the right to receive an accounting of disclosures of your protected health information made by us in the six years prior to the date of the accounting request; and
- You have the right to obtain a paper copy of this notice from us, even if you have already agreed to receive the notice electronically

If you feel your privacy rights or the provisions of this notice of privacy policies has been violated, you have the right to file a formal written complaint. This complaint should be addressed either to the Privacy

Officer at our office, or directly to the Department of Health & Human Services, Office of Civil Rights. Both address appear below. You will not be retaliated against, in any way, for filing a complaint.

For more information about HIPAA
or to file a complaint contact:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington DC 20201
(202) 619-0257
Toll free: (877) 696-6775

Please contact us for more information:

Privacy Officer

Tracy Sneed

Kessler Pediatrics

214-941-6691

# PATIENT CONSENT FORM

**I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:**

- **Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);**
- **Obtaining payment from third party payers (e.g. my insurance company);**
- **The day-to-day healthcare operations of your practice.**

**I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.**

**I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.**

**I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.**

**Signed this day_____of_____, 20_____.**

**Print Patient Name:** _____

**Relationship to Patient:** _____

**Signature:** _____

**Practice Name:** Kessler Pediatrics

**Address:** 1411 N. Beckley Avenue, Suite 164

**City/State/Zip:** Dallas, TX 75203

# Initial History Questionnaire

**Name**

ID NUMBER

FORM COMPLETED BY

DATE COMPLETED

BIRTH DATE

AGE

☐ M ☐ F

## Household

Please list all those living in the child's home.

| Name | Relationship to child | Birth date | Health problems |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Are there siblings not listed? If so, please list their names, ages, and where they live. _____

What is the child's living situation if not with both biological parents?

☐ Lives with adoptive parents ☐ Joint custody ☐ Single custody

☐ Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?

## Birth History ☐ Don't know birth history

Birth weight _____ Was the baby born at term? _____ OR _____ weeks

Were there any prenatal or neonatal complications?

☐ Yes ☐ No Explain _____

Was a NICU stay required? ☐ Yes ☐ No Explain _____

During pregnancy, did mother

Use tobacco ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No

Use drugs or medications ☐ Yes ☐ No ☐ Used prenatal vitamins

What _____ When _____

Was the delivery ☐ Vaginal ☐ Cesarean If cesarean, why?

Was initial feeding ☐ Formula ☐ Breast milk How long breastfed? _____

Did your baby go home with mother from the hospital?

☐ Yes ☐ No Explain _____

## General DK = don't know

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

Does your child have any serious illnesses or medical conditions? ☐ Yes ☐ No ☐ DK Explain _____

Has your child had any surgery? ☐ Yes ☐ No ☐ DK Explain _____

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

Is your child allergic to medicine or drugs? ☐ Yes ☐ No ☐ DK Explain _____

Do you feel your family has enough to eat? ☐ Yes ☐ No ☐ DK Explain _____

## Biological Family History DK = don't know

Have any family members had the following?

| | | | | | |
|---|---|---|---|---|---|
| Childhood hearing loss | ☐ Yes | ☐ No | ☐ DK | Who _____ | Comments _____ |
| Nasal allergies | ☐ Yes | ☐ No | ☐ DK | Who _____ | Comments _____ |
| Asthma | ☐ Yes | ☐ No | ☐ DK | Who _____ | Comments _____ |
| Tuberculosis | ☐ Yes | ☐ No | ☐ DK | Who _____ | Comments _____ |
| Heart disease (before 55 years old) | ☐ Yes | ☐ No | ☐ DK | Who _____ | Comments _____ |
| High cholesterol/takes cholesterol medication | ☐ Yes | ☐ No | ☐ DK | Who _____ | Comments _____ |
| Anemia | ☐ Yes | ☐ No | ☐ DK | Who _____ | Comments _____ |
| Bleeding disorder | ☐ Yes | ☐ No | ☐ DK | Who _____ | Comments _____ |
| Dental decay | ☐ Yes | ☐ No | ☐ DK | Who _____ | Comments _____ |
| Cancer (before 55 years old) | ☐ Yes | ☐ No | ☐ DK | Who _____ | Comments _____ |

*(Biological Family History continued on back side.)*

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

## Biological Family History *(Continued from front side.)* DK = don't know

| | | | | | |
|---|---|---|---|---|---|
| Liver disease | ☐ Yes | ☐ No | ☐ DK | Who _____ | Comments _____ |
| Kidney disease | ☐ Yes | ☐ No | ☐ DK | Who _____ | Comments _____ |
| Diabetes (before 55 years old) | ☐ Yes | ☐ No | ☐ DK | Who _____ | Comments _____ |
| Bed-wetting (after 10 years old) | ☐ Yes | ☐ No | ☐ DK | Who _____ | Comments _____ |
| Obesity | ☐ Yes | ☐ No | ☐ DK | Who _____ | Comments _____ |
| Epilepsy or convulsions | ☐ Yes | ☐ No | ☐ DK | Who _____ | Comments _____ |
| Alcohol abuse | ☐ Yes | ☐ No | ☐ DK | Who _____ | Comments _____ |
| Drug abuse | ☐ Yes | ☐ No | ☐ DK | Who _____ | Comments _____ |
| Mental illness/depression | ☐ Yes | ☐ No | ☐ DK | Who _____ | Comments _____ |
| Developmental disability | ☐ Yes | ☐ No | ☐ DK | Who _____ | Comments _____ |
| Immune problems, HIV, or AIDS | ☐ Yes | ☐ No | ☐ DK | Who _____ | Comments _____ |
| Tobacco use | ☐ Yes | ☐ No | ☐ DK | Who _____ | Comments _____ |

Additional family history _____

## Past History DK = don't know

Does your child have, or has your child ever had,

| | | | | |
|---|---|---|---|---|
| Chickenpox | ☐ Yes | ☐ No | ☐ DK | When _____ |
| Frequent ear infections | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Problems with ears or hearing | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Nasal allergies | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Problems with eyes or vision | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Asthma, bronchitis, bronchiolitis, or pneumonia | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Any heart problem or heart murmur | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Anemia or bleeding problem | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Blood transfusion | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| HIV | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Organ transplant | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Malignancy/bone marrow transplant | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Chemotherapy | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Frequent abdominal pain | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Constipation requiring doctor visits | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Recurrent urinary tract infections and problems | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Congenital cataracts/retinoblastoma | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Metabolic/Genetic disorders | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Cancer | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Kidney disease or urologic malformations | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Bed-wetting (after 5 years old) | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Sleep problems; snoring | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Chronic or recurrent skin problems (eg, acne, eczema) | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Frequent headaches | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Convulsions or other neurologic problems | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Obesity | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Diabetes | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Thyroid or other endocrine problems | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| High blood pressure | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| History of serious injuries/fractures/concussions | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Use of alcohol or drugs | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Tobacco use | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| ADHD/anxiety/mood problems/depression | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Developmental delay | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Dental decay | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| History of family violence | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Sexually transmitted infections | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| Pregnancy | ☐ Yes | ☐ No | ☐ DK | Explain _____ |
| (For girls) Problems with her periods | ☐ Yes | ☐ No | ☐ DK | Explain _____ |

Has had first period ☐ Yes ☐ No Age of first period _____

Any other significant problem _____

**This American Academy of Pediatrics Initial History Questionnaire is consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents,* 3rd Edition.**



HE0328

9-223/0109