

WELCOME TO EAST HAVEN PEDIATRICS, P.C.



We are looking forward to your child's first visit to our practice. In order to make your visit as smooth as possible, please read the following instructions carefully.

1. ALL previous medical records must be transferred to our office. Please sign a record release form with your previous pediatrician to ensure that we have the records prior to scheduling your child's first visit.
2. Please complete all the information in the chart, if you have any questions please contact our office for assistance. Bring the completed information with you to your first office visit.
3. Bring any and all insurance cards with you to all appointments. Please have the insurance information as accurate and updated as possible. We must be listed as the "Primary Care Physician". And please contact your insurance company if you have any questions.
4. Bring any co-pays that apply to your insurance. It is the responsibility of the adult who accompanies the child to the office for all co-pays and fees.
5. If you are the guardian or foster parent, please bring legal paperwork identifying you as such.

Thank you for your cooperation and we look forward to seeing you very soon!



Welcome to East Haven Pediatrics PC. Patient Portal

With the changing times and new requirements by the government, we want to encourage and enhance our patient-provider communications & relationship.

We invite you to register online at our private Patient Portal address:
(<https://adsportal.myadsc.com/PatientPortal/ehpeds>)

To register, you will need

1. a separate email address for each child,
2. Patient's First Name,
3. Last Name,
4. Date of Birth,
5. Zip code and
6. Either your on-file telephone number or last 4 digits of child's social security number.

This information MUST match exactly what we have in our system, so please ask for a demographic printout of your child/children's account information. Prior to final registration, you will be asked for a verification number, an email will be sent to our office and we will either call you with verification number or email you back.

At this time, our portal will be used only for the discharge/recent visit summaries. We hope to implement other options in the future as our technical & software capabilities increase.

If you have any questions about registering, or this portal please do not hesitate to ask. We think this will be a great way for us to interact with you and your family.

What is a Patient Portal?

The Basics: A patient portal is a secure online website that gives patients convenient 24-hour access to personal health information from anywhere with an Internet connection. Using a secure username and password, patients can view health information such as:

- Recent doctor visits
- Discharge summaries
- Medications
- Immunizations
- Allergies
- Lab results

NOT AVAILABLE YET, But In the future, we hope to add some of these depending on our software:

- Download and complete forms
- View educational materials
- Exchange secure e-mail with their health care teams
- Request prescription refills
- Schedule non-urgent appointments
- Check benefits and coverage
- Update contact information
- Make payment

EAST HAVEN PEDIATRICS, P.C.

300 MAIN STREET
EAST HAVEN, CONNECTICUT, 06512
TELEPHONE (203) 469-8882
FAX (203)467-9973

East Haven Pediatrics New Policy for Vaccination Refusal January 1, 2020

On January 1, 2020, East Haven Pediatrics will no longer see existing patients or accept new patients whose parents/guardians refuse to vaccinate their child. Immunizations are an integral foundation of pediatric practice. East Haven Pediatrics philosophy of care is to provide comprehensive, safe and evidence based care to all of our patients.

Our new policy has been implemented for a number of reasons. The American Academy of Pediatrics strongly endorses universal immunization. Unimmunized children pose a risk to other children who lack immunity to vaccine preventable infections (ex. unimmunized infants, immunocompromised children, children undergoing chemotherapy). In addition, the State of Connecticut mandates vaccination for children who attend daycare or public schools.

Communication and trust are key components to any provider-patient relationship. The providers at East Haven Pediatrics are committed to the safety and well-being of your child. As always, we are here to answer any question or concerns you may have regarding this new policy or any issue regarding the care of your child.

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH



Notice to Patients about reporting to CT WiZ

As required by law and to protect your health, your doctor will share immunization information (i.e., "shots" or "vaccines") with the State of Connecticut Department of Public Health (DPH). DPH will store your shots in its immunization system called CT WiZ. CT WiZ helps make sure you get the shots needed to protect you against vaccine preventable diseases. If your shot record is lost or not available, DPH can share it with you and your doctor. You can choose to exclude your shot information from CT WiZ by sending a signed written request to the DPH Immunization Program. Immunization systems help prevent and control disease. All information is kept confidential as required by law.

Notificación a pacientes acerca el reporte de inmunizaciones a CT WiZ

Según lo exige la ley y para proteger su salud, su médico compartirá la información de inmunizaciones ("vacunas") con el Departamento de Salud Pública (DPH) del Estado de CT. DPH almacenará sus vacunas en su sistema de inmunización llamado CT WiZ. CT WiZ ayuda a asegurar que reciba las vacunas necesarias para protegerlo contra enfermedades peligrosas. Si el registro de sus vacunas se pierde o no está disponible, DPH puede compartirlo con usted y su médico. Usted puede optar por excluir la información de sus vacunas de CT WiZ enviando una solicitud firmada por escrito al Programa de Inmunización de DPH. Los sistemas de inmunización ayudan a prevenir y controlar enfermedades. Toda la información se mantiene confidencial como lo exige la ley.

Connecticut Department of Public Health Immunization Program
Departamento de Salud Pública de Connecticut Programa de Inmunización
Phone: 860-509-7929 Fax: 860-707-1925
Visit: ct.gov/getmyvaccinerecord



SCAN ME



rev 12/2023

NOTICE OF PRIVACY PRACTICES

EAST HAVEN PEDIATRICS PC
300 MAIN STREET
EAST HAVEN, CT 06512

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you. We may also call you by name while in our waiting room.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. **Your authorization is needed to fill out or fax information for school, camp or sports physicals.**

You have the following rights with respect to your protected health information, which you can exercise by presenting in a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it. Your request must tell us: 1. What information you want to limit. 2. Whether you want to limit how we use or disclose your information, or both. 3. To whom you want the restriction to apply.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations. You must specify how or where you wish to be contacted. We have a right to deny based on our technology.
- The right to inspect and copy your protected health information. This does not include psychotherapy notes. We may also charge a fee for the costs of copying, mailing, or other supplies associated with your requests. We also may deny access in certain specified situations, such as when a health care provider believes access could cause harm to the individual or another. You have the right to have such denials reviewed by a licensed health care professional (who is designated by East Haven Pediatrics PC and who did not participate in the original decision).
- The right to amend your protected health information. Your request must include the reason you are seeking a change. We may deny your request if the information was not created by our practice or you ask to amend a record that is already accurate and complete.
- The right to receive an accounting of disclosures of protected health information. Indicate the time period of requests and a fee may be charged for this information. The time period may not be longer than six years and may not include dates before 4-14-03. The first accounting that you request will be free of charge. There will be a fee for additional lists within the same time period.
- The right to obtain a paper copy of this notice from us upon request.

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

This notice is effective as of _____, 20 ____ and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complain with our office, or with the Department of Health & Human Service, office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

East Haven Pediatrics PC
 300 Main Street
 East Haven, CT 06512
 Telephone: (203) 469-8882
 Fax: (203) 467-9973

For more information about HIPAA or to file a complaint:
 The U.S. Department of Health & Human Services
 Office of Civil Rights
 200 Independence Avenue, S.W.
 Washington, D.C. 20201
 (202)619-0257
 Toll free: 1-877-696-6775

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

EAST HAVEN PEDIATRICS, P.C.
300 MAIN STREET
EAST HAVEN, CT 06512

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved with that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on the Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:
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ACCOUNT NUMBER: _____

DATE: _____ FORM FILLED OUT BY: _____ RELATIONSHIP: _____

PATIENT'S LEGAL NAME: _____ Male/Female DATE OF BIRTH: _____

SSN: _____ Cell: _____ PATIENT'S EMAIL: _____

RACE: American Indian or Alaskan Native, Asian, Black or African American, Native Hawaiian or other Pacific Islander, White, or OTHER: _____ ETHNICITY: Hispanic or Latino/Not Hispanic or Latino/UNKNOWN LANGUAGE: _____

Unless we have legal papers in your child's chart indicating otherwise, both parents are presumed to have legal custody/decision making for the child.

IMPORTANT: Please circle below if mother, father, stepparent. (If guardian, please write in relationship.)

If biological or adoptive parents live in separate households, please include both parental addresses and contacts below.

BIOLOGICAL OR ADOPTIVE PARENTS: Mother: _____

Father: _____

Parents: Married Unmarried Divorced Separated Widowed

HOUSEHOLD #1 (PATIENT'S PRIMARY RESIDENCE)

House Phone: _____ Child spends time in this household? _____

Mother/Stepmother/Guardian: _____ Relationship: _____ DOB: _____ SSN: _____

Cell Phone: _____ Work Phone: _____ Employer Name: _____

Father/Stepfather/Guardian: _____ Relationship: _____ DOB: _____ SSN: _____

Cell Phone: _____ Work Phone: _____ Employer Name: _____

Home Address: _____

City: _____ State: _____ Zip code: _____

HOUSEHOLD #2

House Phone: _____ Child spends time in this household? _____

Mother/Stepmother/Guardian: _____ Relationship: _____ DOB: _____ SSN: _____

Cell Phone: _____ Work Phone: _____ Employer Name: _____

Father/Stepfather/Guardian: _____ Relationship: _____ DOB: _____ SSN: _____

Cell Phone: _____ Work Phone: _____ Employer Name: _____

Home Address: _____

City: _____ State: _____ Zip code: _____

EAST HAVEN PEDIATRICS, P.C.
300 MAIN STREET
EAST HAVEN, CT 06512

AUTHORIZED REPRESENTATIVE FORM

CHILD'S NAME: _____ DATE OF BIRTH: _____

CHILD'S NAME: _____ DATE OF BIRTH: _____

CHILD'S NAME: _____ DATE OF BIRTH: _____

CHILD'S NAME: _____ DATE OF BIRTH: _____

I, _____ authorize the following people to bring my child(ren) to East Haven Pediatrics, P.C. and to authorize any medical decisions and treatment presented at **SICK VISITS ONLY**.

NAME

RELATIONSHIP

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

SIGNATURE: _____ DATE: _____

I understand that I may revoke this authorization at any time by giving written notice to East Haven Pediatrics, P.C.

East Haven Pediatrics, P.C.
300 Main Street
East Haven, CT 06512
(203) 469-8882

Consent to Leave Voicemail on Answering Machine

By signing this "Consent to Leave Voicemails", you consent to East Haven Pediatrics staff leaving voicemail messages containing your child's detailed medical information on the phone number(s) listed below. This information may include, but not limited to, demographic information (partial or full name, date of birth, address, etc.), billing information, medical information (appointment dates, diagnosis, medications, test results, etc.).

- Home Phone _____
- Cell Phone _____
- Do not leave information on any phone number

I understand that East Haven Pediatrics cannot require me to sign this consent form in order to receive medical care.

I understand that I have the right to revoke this consent at any time by sending a written request to East Haven Pediatrics. This "Consent to Leave Voicemail" is valid until such revocation is received by East Haven Pediatrics. My decision to revoke this consent does not apply to any information disclosed in a voicemail prior to the date of my revocation of this consent.

I understand that I am entitled to a copy of this completed consent form.

CHILD'S NAME: _____ DATE OF BIRTH: _____

CHILD'S NAME: _____ DATE OF BIRTH: _____

CHILD'S NAME: _____ DATE OF BIRTH: _____

CHILD'S NAME: _____ DATE OF BIRTH: _____

Signature of Parent/Guardian

Date

Broken Appointment Policy

Our goal is to provide quality individualized medical care in a timely manner. "No-shows", late shows and missed appointments, or appointments cancelled without the 24 hour notice are considered Broken Appointments. Your appointment is a time especially reserved for you; we do not double book times. When you break appointments, you inconvenience those individuals who need access to medical care in a timely manner and add to the cost of providing care for all our patients.

As of August 1, 2011, we will now be charging a fee for Broken Appointments. This policy enables us to better utilize available appointments for our patients in need of medical care.

Our office requires 24 hours notice to cancel an appointment. If an appointment is missed or cancelled without 24 hours' notice or arriving 15 minutes after your scheduled appointment, you will be charged for the fee. Missed appointment fees are not covered by your insurance.

We will make every effort to conduct a courtesy call to remind you of your scheduled appointment. Please provide us the best possible number to contact you with regards to your appointment. These calls are a courtesy only. You are ultimately responsible to remember these scheduled appointments, and our failure to call does not relieve you of that responsibility. Please hold onto your appointment cards or blue receipts.

Our procedure for Broken appointments

- The first time there is a Broken Appointment, as defined above, without an adequate excuse, it will be documented in your chart, a reminder letter stating the policy again will be sent to you and the fee is waived.
- The 2nd time will result in a fee of \$30 billed to patient's account.
- The 3rd time will result in a fee of \$50 billed to patient's account and you will be asked to seek care with another pediatrician who can better accommodate your scheduling requirements.
- All fees must be paid in full prior to any rescheduled appointments

We understand that last minute changes in your schedule may be unavoidable and we will try to accommodate those changes as best we can. We will work with you to try to schedule times that are best for you. Patients who habitually reschedule for inadequate reason will be referred to another pediatric office.

We have the right to make exceptions based on a case to case basis and reserve the right to change this policy. If you have any questions, we will be happy to answer them for you.

Broken Appointment Policy

I understand the Broken Appointment policy and agree to abide by it.

Child's Names _____

Signature of Parent/Guardian

Date

Best Contact Number

Medical History Questionnaire



EAST HAVEN PEDIATRICS, P.C.
 300 Main Street
 East Haven, CT 06512
 (203) 469-8882

Date			
Patient Name	Sex (circle one) M F	Date of Birth	Today's Date:
Form Completed By:	Informant (guardian, parent):	Ethnicity:	

CHILD'S MEDICAL HISTORY		
Has your child ever had:		
Allergies (List) (Food or Meds)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Asthma/Wheezing	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Asthma Action Plan	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Pneumonia	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Chicken Pox (Year) _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Frequent Ear Infections	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Vision Problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Hearing Problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Skin Problems/Eczema/Hives	<input type="checkbox"/> No	<input type="checkbox"/> Yes
TB/Lung Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Seizures/Epilepsy	<input type="checkbox"/> No	<input type="checkbox"/> Yes
High Blood Pressure	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Heart Defects/Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Liver Disease/Hepatitis	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Diabetes	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Kidney Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Bladder Infections	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Physical or Learning Disabilities	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Bleeding Disorders/Hemophilia	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Sexually Transmitted Infections	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Emotional/Behavioral Problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Depression/Suicidal Thoughts	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Hospitalizations/Surgeries Physical/Sexual Abuse	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Emotional Abuse	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Bone or Joint Injuries	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Dental Problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Obesity/Overweight	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Eating Disorders	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Anorexia Nervosa	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Bulimia	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Learning Disabilities	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Attention Deficit Disorder	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Lead Poisoning	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Vaccines Up-to-Date	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Other Concerns: _____ _____		
Current Medication(s): (List): _____ _____ _____ _____		
Reviewed by:		

FAMILY MEDICAL HISTORY			
Has any parent (P), grandparent (GP), aunt (A), uncle (U), sister (S), or brother (B) had:			
Allergies (List)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Asthma/Wheezing	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
TB/Lung Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Cystic Fibrosis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
HIV/AIDS	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Suicide Attempts	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Heart Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Sudden Cardiac Death	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
High Blood Pressure/Stroke	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
High Cholesterol	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Blood Disorders	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Sickle Cell	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Anemia	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Thalassemia	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Clotting Disorders	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Diabetes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Seizures	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Mental Illness	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Depression	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Suicide Attempts	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Cancer	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Breast	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Cervical	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Colorectal	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Other _____			
Birth Defects	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Hearing Loss	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Speech Problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Kidney Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Alcohol/Drug Abuse	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Hepatitis/Liver Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Thyroid Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Learning Problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Attention Deficit Disorder	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Mental Retardation	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Family Violence	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who?
Other Concerns: _____ _____			
Has any family member ever had an unexplained, unexpected death before age 50? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, describe on back)			
Date of Review:			

Medical History Questionnaire

PREGNANCY AND BIRTH HISTORY	
Adopted	<input type="checkbox"/> No <input type="checkbox"/> Yes
Prenatal care	<input type="checkbox"/> No <input type="checkbox"/> Yes
Illnesses during pregnancy	<input type="checkbox"/> No <input type="checkbox"/> Yes
Medications during pregnancy	<input type="checkbox"/> No <input type="checkbox"/> Yes
Alcohol/drug abuse	<input type="checkbox"/> No <input type="checkbox"/> Yes
Tobacco use	<input type="checkbox"/> No <input type="checkbox"/> Yes
Problems at birth	<input type="checkbox"/> No <input type="checkbox"/> Yes
Mom	
Miscarriage	<input type="checkbox"/> No <input type="checkbox"/> Yes
Toxemia	<input type="checkbox"/> No <input type="checkbox"/> Yes
Baby	
Jaundice	<input type="checkbox"/> No <input type="checkbox"/> Yes
Heart Murmur	<input type="checkbox"/> No <input type="checkbox"/> Yes
Infection	<input type="checkbox"/> No <input type="checkbox"/> Yes
Breathing Problems	<input type="checkbox"/> No <input type="checkbox"/> Yes
Birth Defects	<input type="checkbox"/> No <input type="checkbox"/> Yes
Other:	
Name of Hospital: _____	
Month of gestation when child was born: _____	
Type of delivery: <input type="checkbox"/> Vaginal <input type="checkbox"/> C-section <input type="checkbox"/> VBAC	
Birth Weight _____	
Discharge Weight _____	
Newborn Hearing Screen	<input type="checkbox"/> No <input type="checkbox"/> Yes
Did baby receive Hep B vaccine	<input type="checkbox"/> No <input type="checkbox"/> Yes
Date of Hepatitis B immunization: _____	
FEEDING AND DIGESTION	
Breast fed <input type="checkbox"/> Formula <input type="checkbox"/>	
Severe colic in first 3 months	<input type="checkbox"/> No <input type="checkbox"/> Yes
Feeding problems	<input type="checkbox"/> No <input type="checkbox"/> Yes
Good appetite	<input type="checkbox"/> No <input type="checkbox"/> Yes
Takes vitamins	<input type="checkbox"/> No <input type="checkbox"/> Yes
Eats balanced diet	<input type="checkbox"/> No <input type="checkbox"/> Yes
Constipation problems	<input type="checkbox"/> No <input type="checkbox"/> Yes
Food allergies/issues	<input type="checkbox"/> No <input type="checkbox"/> Yes

PSYCHOSOCIAL HISTORY	
Who lives in household: _____	
<input type="checkbox"/> Rent <input type="checkbox"/> Own <input type="checkbox"/> Shelter	
Who cares for child: _____	
Is child in daycare: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Type: <input type="checkbox"/> Center	
<input type="checkbox"/> Private home	
<input type="checkbox"/> Family member home	
Date of Birth: _____	
Mother _____	
Father _____	
Parents divorced/separated: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Parents working:	
Mother	<input type="checkbox"/> No <input type="checkbox"/> Yes
Father	<input type="checkbox"/> No <input type="checkbox"/> Yes
Parents use tobacco:	
Mother	<input type="checkbox"/> No <input type="checkbox"/> Yes
Father	<input type="checkbox"/> No <input type="checkbox"/> Yes
Child use tobacco (12 yrs +) <input type="checkbox"/> No <input type="checkbox"/> Yes	
Sleep Problems <input type="checkbox"/> No <input type="checkbox"/> Yes	
Foster Care	
Dates: _____	
Other Languages _____	
MEDICAL HISTORY	
Broken bones	<input type="checkbox"/> No <input type="checkbox"/> Yes
Serious accidents	<input type="checkbox"/> No <input type="checkbox"/> Yes
Operations	<input type="checkbox"/> No <input type="checkbox"/> Yes
Hospitalizations	<input type="checkbox"/> No <input type="checkbox"/> Yes
ER visits/Urgent Care	<input type="checkbox"/> No <input type="checkbox"/> Yes
Explain: _____	

Additional Information:	

