

Lisa P. Allardice MD, F.A.A.P.  
 Mindy Scheible, NP-C  
 Diana Hess, CPNP  
 Carlie Frederick, APRN-BC

# Pediatric Associates of LaGrange, P.C.

Today's Date: \_\_\_\_\_

|   |  |  |  |                     |  |                         |                             |                      |                             |        |   |      |   |  |             |  |  |   |  |   |  |
|---|--|--|--|---------------------|--|-------------------------|-----------------------------|----------------------|-----------------------------|--------|---|------|---|--|-------------|--|--|---|--|---|--|
| P   | PATIENT FIRST NAME:                          |  |  | MIDDLE NAME:        |  |                         | LAST NAME:                  |                      |                             |        |   |      |   |  |             |  |  |   |  |   |  |
|   | ..... MARK THE NAME PATIENT GOES BY .....    |  |  |                     |  |                         |                             |                      |                             |        |   |      |   |  |             |  |  |   |  |   |  |
|   | PATIENT SSN:                                 |  |  | PATIENT DOB:        |  |                         | SEX: M    F                 |                      |                             |        |   |      |   |  |             |  |  |   |  |   |  |
|   | .....  |  |  |                     |  |                         |                             |                      |                             |        |   |      |   |  |             |  |  |   |  |   |  |
|   | BILL PAYER:                                  |  |  | PATIENT LIVES WITH: |  |                         |                             |                      |                             |        |   |      |   |  |             |  |  |   |  |   |  |
|   | ADDRESS:                                     |  |  | ADDRESS:            |  |                         |                             |                      |                             |        |   |      |   |  |             |  |  |   |  |   |  |
|   | CITY:  |  |  | STATE:              |  | ZIP:                    |                             | CITY:                |                             | STATE: |   | ZIP: |   |  |             |  |  |   |  |   |  |
|   | .....  |  |  |                     |  |                         |                             |                      |                             |        |   |      |   |  |             |  |  |   |  |   |  |
|   | MOTHER'S CELL PHONE:                         |  |  | -                   |  | -                       |                             | MOTHER'S WORK PHONE: |                             |        | - |      | - |  | HOME PHONE: |  |  | - |  | - |  |
|   | FATHER'S CELL PHONE:                         |  |  | -                   |  | -                       |                             | FATHER'S WORK PHONE: |                             |        | - |      | - |  | ALT. PHONE: |  |  | - |  | - |  |
| .....   |  |  |  |                     |  |                         |                             |                      |                             |        |   |      |   |  |             |  |  |   |  |   |  |
| A   | Mother's Name:                               |  |  | Maiden Name:        |  |                         | Mother's DOB:               |                      |                             |        |   |      |   |  |             |  |  |   |  |   |  |
|   | Mother's Employer:                           |  |  |                     |  |                         | Mother's SSN:               |                      |                             |        |   |      |   |  |             |  |  |   |  |   |  |
|   | Father's Name:                               |  |  | Father's SSN:       |  |                         | Father's DOB:               |                      |                             |        |   |      |   |  |             |  |  |   |  |   |  |
|   | Father's Employer:                           |  |  |                     |  |                         |                             |                      |                             |        |   |      |   |  |             |  |  |   |  |   |  |
|   | PRIMARY INSURANCE:                           |  |  | DAD'S INSURANCE     |  |                         | MOM'S INSURANCE             |                      |                             | OTHER: |   |      |   |  |             |  |  |   |  |   |  |
|   | SECONDARY INSURANCE:                         |  |  | DAD'S INSURANCE     |  |                         | MOM'S INSURANCE             |                      |                             | OTHER: |   |      |   |  |             |  |  |   |  |   |  |
| .....   |  |  |  |                     |  |                         |                             |                      |                             |        |   |      |   |  |             |  |  |   |  |   |  |
| L   | NUMBER OF PEOPLE LIVING IN CHILD'S HOUSEHOLD |  |  |                     |  |                         | MOTHER IN HOUSEHOLD: Y    N |                      | FATHER IN HOUSEHOLD: Y    N |        |   |      |   |  |             |  |  |   |  |   |  |
|   | .....  |  |  |                     |  |                         |                             |                      |                             |        |   |      |   |  |             |  |  |   |  |   |  |
| S   | SIBLING:                                     |  |  |                     |  |                         | AGE:                        |                      | HEALTHY: Y    N             |        |   |      |   |  |             |  |  |   |  |   |  |
|   | SIBLING:                                     |  |  |                     |  |                         | AGE:                        |                      | HEALTHY: Y    N             |        |   |      |   |  |             |  |  |   |  |   |  |
|   | SIBLING:                                     |  |  |                     |  |                         | AGE:                        |                      | HEALTHY: Y    N             |        |   |      |   |  |             |  |  |   |  |   |  |
|   | SIBLING:                                     |  |  |                     |  |                         | AGE:                        |                      | HEALTHY: Y    N             |        |   |      |   |  |             |  |  |   |  |   |  |
| .....   |  |  |  |                     |  |                         |                             |                      |                             |        |   |      |   |  |             |  |  |   |  |   |  |
| PERSONS ALLOWED TO BRING CHILD TO OFFICE VISITS FOR TREATMENT |  |  |  |                     |  | RELATIONSHIP TO PATIENT |                             |                      |                             |        |   |      |   |  |             |  |  |   |  |   |  |

# PATIENT MEDICAL HISTORY

**PATIENT NAME:** \_\_\_\_\_

*Please circle if your child has had any of the following:*

|                  |                          |                         |                          |                   |
|------------------|--------------------------|-------------------------|--------------------------|-------------------|
| Bronchiolitis    | Kidney Disease           | Blackout Spells         | Congenital Heart Disease | Behavior Problems |
| Bronchitis       | Kidney Infections        | Brain Disease or Injury | Neurofibromatosis        | Eye Problems      |
| Persistent Cough | Problems Urinating       | Cerebral Shunt          | Tuberous Sclerosis       | Skin Problems     |
| Wheezing         | Urinary Tract Infections | Headaches               | Chicken Pox              | Immune Problems   |
| Whooping Cough   | Urologic Malformations   | Seizures                | Mumps                    | Thyroid Problems  |
| Allergies        | Constipation             | Staring Spells          | Measles                  | Sleep Problems    |
| Hay Fever        | Diarrhea                 | Broken Bones            | German Measles           | Bleeding Problems |
| Sinusitis        | Excess Weight Gain       | Joint Problems          | Malignancy or Bone       | Eating Problems   |
| Scarlet Fever    | Excess Weight Loss       | High Blood Pressure     | marrow Transplant        | Prematurity       |
| Strep Throat     | Frequent Vomiting        | Treatment with medicine | Solid Organ Transplant   |                   |
| Tonsillitis      | Soiling Pants            | known to raise blood    | Poisoning                |                   |
| Bed Wetting      | Stomach Ache             | pressure                | Meningitis               |                   |

*Please specify any allergies your child has had in the past:* \_\_\_\_\_

*Please list any medical problems, surgeries, specialists:* \_\_\_\_\_

*Please list all medications currently taken:* \_\_\_\_\_

**Hospitalizations:** \_\_\_\_\_

**Circle if your child had any of the following with baby shots (immunizations):** High Fever, Seizure, Leg Swelling, Uncontrollable Screaming, Other \_\_\_\_\_

**Pregnancy, labor, delivery and nursery:** Was your pregnancy planned?      Yes      No

**Circle if you had any of the following during pregnancy:**

|                                 |                         |                       |                      |
|---------------------------------|-------------------------|-----------------------|----------------------|
| C-Section                       | Labor longer than 1 day | Hepatitis B or C      | Other pain medicines |
| Reason for C-Section            | Early labor             | Syphillis             | Kidney infections    |
| _____                           | Vacuum                  | Gonorrhea             | Other infections     |
| Spinal/Anesthesia               | Forceps                 | High blood pressure   | Medicines other than |
| Infection or fever during labor | Group B Strep           | Alcohol or drug abuse | prenatal vitamins    |
| Water leaking > 1 day           | HIV                     | Cigarette use         | Cigarette Exposure   |

**Circle if the baby had any of the following problems:**

|                           |              |                      |                              |
|---------------------------|--------------|----------------------|------------------------------|
| Problem right after birth | Infection    | Jaundice             | Longer hosp stay than you    |
| Breathing problems        | Low sugar    | IV or IV antibiotics | Low blood count or anemia    |
| Feeding problems          | Heart murmur | ICU                  | Tube, bag or mask to breathe |

What was the child's birth weight? \_\_\_\_\_ What was the child's Apgar scores? \_\_\_\_\_  
 Was the baby full term? If not, how many weeks early? \_\_\_\_\_ If child stayed in the ICU, where and how long? \_\_\_\_\_  
 Problems while in ICU? \_\_\_\_\_  
 Any signs or symptoms of maternal/paternal depression since child's birth? Y/N Explain: \_\_\_\_\_

**Family History: Circle in anyone in your family has any of the following:**

|   |                              |                              |                         |                            |
|---|------------------------------|------------------------------|-------------------------|----------------------------|
| Y/N High cholesterol  | Y/N Gallbladder disease      | Y/N Seizures                 | Y/N Eye problems        | Y/N Birth defects          |
| Y/N High blood pressure   | Y/N Hepatitis B,C            | Y/N Migraines                | Y/N Deafness            | Y/N Cancer                 |
| Y/N Rheumatic Fever   | Y/N Thyroid disease          | Y/N Asthma                   | Y/N Allergies           | Y/N Early death            |
| Y/N Kidney stones   | Y/N Diabetes                 | Y/N Cystic Fibrosis          | Y/N Eczema              | Y/N Mental disease         |
| Y/N Congenital kidney disease                                       | Y/N Overweight               | Y/N TB (Tuberculosis)        | Y/N Skin problems       | Y/N Mental retardation     |
| Y/N Kidney disease  | Y/N Excessive weight gain    | Y/N Abnormal fingers or toes | Y/N Cleft lip or palate | Y/N Behavior problems      |
| Y/N Ulcers  | Y/N Height less than 5' 0"   | Y/N Joint disease            | Y/N Bleeding problems   | Y/N Learning problems      |
| Y/N Bowel disease (Ileitis)   | Y/N Height greater than 6'4" | Y/N Crippling arthritis      | Y/N Leukemia            | Y/N Reading problems       |
| Y/N Liver problems  | Y/N Immune problems          | Y/N Sickle cell disease      | Y/N Abnormal teeth      | Y/N Hyperactivity/ADD/ADHD |
| Y/N Alcohol problem   | Y/N Stroke                   | Y/N Blindness                | Y/N Down's Syndrome     | Other _____                |
| Y/N Heart Attack (man less than 40 years/ woman less than 50 years) |                              |                              |                         |                            |

PEDIATRIC ASSOCIATES OF LAGRANGE, P.C.  
LISA P. ALLARDICE, M.D., F.A.A.P.  
DIANA L. HESS, CPNP

PATIENT CONSENT FOR USE AND DISCLOSURE  
OF PROTECTED HEALTH INFORMATION

With my consent, Pediatric Associates of LaGrange, P.C. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Pediatric Associates of LaGrange's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Pediatric Associates of LaGrange reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Pediatric Associates of LaGrange's Privacy Officer at 205 Calumet Center Road, LaGrange, GA, 30241.

With my consent, Pediatric Associates of LaGrange may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Pediatric Associates of LaGrange may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With my consent, Pediatric Associates of LaGrange may e-mail and/or text to me appointment reminders and patient statements. I have the right to request that Pediatric Associates of LaGrange restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting Pediatric Associates of LaGrange's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Pediatric Associates of LaGrange may decline to provide treatment to me.

I authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to Pediatric Associates of LaGrange, P.C., for all medical or surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments and any charges not paid by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original.

\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Parent or Legal Guardian

\_\_\_\_\_  
Print Patient's Name





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

### Lead Risk Assessment Questionnaire

Circle Yes or No

\*If Yes, please explain

- |  |     |    |       |
|--|-----|----|-------|
| 1. Does your child live in or often visit a house that may have been built before 1978?                                | Yes | No | _____ |
| 2. Does your child live in or often visit a house that is being remodeled or is having paint removed?                  | Yes | No | _____ |
| 3. Does your child live with or often visit another child that has an elevated blood lead level?                       | Yes | No | _____ |
| 4. Does your child live with anyone that works at a job where lead may be found or has a hobby that uses it?           | Yes | No | _____ |
| 5. Does your child chew on or eat any non-food items like paint chips or dirt?   | Yes | No | _____ |
| 6. Does your child live near an active lead smelter, battery recycling plant or other industry likely to release lead? | Yes | No | _____ |
| 7. Does your child receive medicines such as <i>greta</i> , <i>azarcon</i> , <i>kohl</i> or <i>pay-loo-ah</i> ?        | Yes | No | _____ |

### Risk Factors for Hearing Loss

- |   |     |    |
|---|-----|----|
| 1. Parent or caregiver concern regarding hearing, speech, language, or developmental delay            | Yes | No |
| 2. Family history of permanent childhood hearing loss   | Yes | No |
| 3. NICU stay greater than five days, ECMO, ototoxic medications, loop diuretics, exchange transfusion | Yes | No |
| 4. In utero infections such as CMV, herpes, rubella, syphilis, Toxoplasmosis                          | Yes | No |
| 5. Craniofacial anomalies, especially involving the ear and temporal bone                             | Yes | No |
| 6. Stigmata of syndromes known to cause hearing loss, Eustachian tube dysfunction                     | Yes | No |
| 7. Syndromes associated with hearing loss or progressive or late-onset hearing loss                   | Yes | No |
| 8. Neurodegenerative disorders or sensory motor neuropathies  | Yes | No |
| 9. Postnatal infections associated with sensorineural hearing loss including bacterial meningitis     | Yes | No |
| 10. Head trauma   | Yes | No |
| 11. Chemotherapy  | Yes | No |
| 12. Recurrent or persistent ear infection for at least 3 months                                       | Yes | No |

Parent Signature \_\_\_\_\_

Date \_\_\_\_\_

Please check the box and sign if there have been no changes to the above answers since the last checkup.

- |   |               |            |
|---|---------------|------------|
| <input type="checkbox"/> Parent Signature _____ | Witness _____ | Date _____ |
| <input type="checkbox"/> Parent Signature _____ | Witness _____ | Date _____ |
| <input type="checkbox"/> Parent Signature _____ | Witness _____ | Date _____ |
| <input type="checkbox"/> Parent Signature _____ | Witness _____ | Date _____ |
| <input type="checkbox"/> Parent Signature _____ | Witness _____ | Date _____ |
| <input type="checkbox"/> Parent Signature _____ | Witness _____ | Date _____ |
| <input type="checkbox"/> Parent Signature _____ | Witness _____ | Date _____ |
| <input type="checkbox"/> Parent Signature _____ | Witness _____ | Date _____ |

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



# Bright Futures Adolescent Supplemental Questionnaire—Older Child/Younger Adolescent Visits

For us to provide you with the best possible health care, we would like to get to know you better and know how things are going for you. Our discussions with you are private. We hope you will feel free to talk openly with us about yourself and your health. Information is not shared with other people without your permission unless we are concerned that someone is in danger. Thank you for your time.

Your Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Your Age \_\_\_\_\_ Your Sex (circle one): M F Your Grade (in school) \_\_\_\_\_

## Your Growing and Changing Body: Physical Growth and Development

|     |   |     |           |     |
|-----|---|-----|-----------|-----|
| 1.  | Do you live in your parents' home?  | Yes | Sometimes | No  |
| 2.  | Do you receive health care from anyone besides a medical doctor (such as an acupuncturist, herbalist, or other healer)?   | No  |           | Yes |
| 3.  | Do you brush your teeth twice a day?  | Yes |           | No  |
| 4.  | Do you floss once a day?  | Yes |           | No  |
| 5.  | Have you seen a dentist in the past year?   | Yes |           | No  |
| 6.  | Do you eat 5 or more helpings of fruits and vegetables each day?  | Yes |           | No  |
| 7.  | Do you drink milk and eat yogurt, cheese, or other calcium-rich foods (such as dark-green leafy vegetables, or calcium-fortified orange juice or cereal) at least 3 times each day? | Yes |           | No  |
| 8.  | Do you eat more than 1 fast food meal per week?   | No  | Sometimes | Yes |
| 9.  | Do you participate in any physical activities, such as walking, skateboarding, dancing, swimming, or playing basketball, for a total of 1 hour each day?                            | Yes |           | No  |
| 10. | Do you drink more than 1 soda or juice drink each day?  | No  |           | Yes |
| 11. | Do you watch TV, play video games, or spend time on the computer for more than 2 hours per day (not including computer time for homework)?  | No  |           | Yes |
| 12. | Do you have any concerns or questions about the size or shape of your body, or physical appearance?   | No  |           | Yes |
| 13. | Do you have a problem with your weight (such as underweight, overweight, anorexia, or bulimia)?   | No  |           | Yes |
| 14. | Are you on a diet to lose weight?   | No  |           | Yes |
| 15. | Do you eat meals together as a family?  | Yes |           | No  |
| 16. | Have you talked about body changes and puberty with your parents?   | Yes |           | No  |
| 17. | Do you have a TV in your bedroom?   | No  |           | Yes |
| 18. | Have you talked to your parents about waiting to have sex?  | Yes |           | No  |
| 19. | For females: Have you gotten your period?   | Yes |           | No  |
| 20. | If yes, are you having any problems with or do you have any questions about your period?  | No  | Sometimes | Yes |



**School and Friends: Social and Academic Competence**

|     |   |     |           |     |
|-----|---|-----|-----------|-----|
| 21. | Do you go to school?  | Yes |           | No  |
|     | Are you having any problems in school?  | No  | Sometimes | Yes |
| 22. | Circle all that apply: grades worse than last year failing grade homework<br>suspension this year fighting missing school other _____ |     |           |     |
| 23. | Is doing well in school important to you?   | Yes |           | No  |
| 24. | Do your parents know your friends and their families?   | Yes |           | No  |
| 25. | Do you try to see things from another person's point of view?   | Yes |           | No  |
| 26. | Do you try to think through solutions by yourself?  | Yes |           | No  |

**Violence and Injuries: Violence and Injury Prevention**

|     |   |     |           |     |
|-----|---|-----|-----------|-----|
| 27. | Do you always wear a seat belt when riding in a car, truck, or van?   | Yes | Sometimes | No  |
| 28. | Do you ever carry a gun (even to protect yourself) or have access to a gun at home or in places where you spend time? | No  | Sometimes | Yes |
| 29. | Do you wear a helmet when you in-line skate, skateboard, bicycle, ski, or snowboard?                                  | Yes | Sometimes | No  |
| 30. | Is there someone at home, school, or anywhere else who has made you feel afraid, threatened you, or hurt you?         | No  |           | Yes |
| 31. | Do you have a person you can call for a ride if you're feeling unsafe with someone?                                   | Yes |           | No  |

**How You Are Feeling: Emotional Well-being**

|     |  |     |           |     |
|-----|--|-----|-----------|-----|
| 32. | Even with usual ups and downs, do you feel you enjoy life?                                     | Yes |           | No  |
| 33. | Do your parents praise you when you do something good or learn something new?                  | Yes |           | No  |
| 34. | Do you spend time talking with your parents every day?   | Yes |           | No  |
| 35. | Do you clearly discuss with your parents their rules and how you should act?                   | Yes |           | No  |
| 36. | Do you worry a lot or feel overly stressed out?  | No  | Sometimes | Yes |
| 37. | When you are angry, do you do violent things?  | No  |           | Yes |
| 38. | Do you continue to remember or think about an unpleasant experience that happened in the past? | No  |           | Yes |

*continued on page 3*





**Feeling Happy: Emotional Well-being** *continued from page 2.*

|     |  |     |  |     |
|-----|--|-----|--|-----|
| 39. | Do you do things as a family?  | Yes |  | No  |
| 40. | During the past few weeks have you often felt sad or down, had difficulty sleeping, or frequently felt irritable or as though you have nothing to look forward to? | No  |  | Yes |
| 41. | Do you talk with your parents about relationships and sex?   | Yes |  | No  |
| 42. | Do you talk with your parents about alcohol and drugs?   | Yes |  | No  |
| 43. | Have you ever seriously thought about killing yourself, made a plan, or tried to kill yourself?  | No  |  | Yes |

**Healthy Behavior Choices: Risk Reduction**

|     |   |    |           |     |
|-----|---|----|-----------|-----|
| 44. | Does anyone you live with smoke cigarettes or cigars or chew tobacco? | No | Sometimes | Yes |
|-----|---|----|-----------|-----|



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DEDICATED TO THE HEALTH OF ALL CHILDREN™

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