PEDIATRIC PERIODIC HEALTH HISTORY UPDATE

Patient Name: _____ Age: _____ Date of Birth: _____

Primary Care Provider (PCP): _____ Reason for today's visit: _____

Other physician's involved in my care: _____

General Health (circle): Excellent Good Fair Poor

BIRTH HISTORY:

			COMMENT
Did you have any illness or health problems during the pregnancy?	❑ No	❑ Yes	
Any problems with birth and delivery?	❑ No	❑ Yes	
Did the baby come early?	❑ No	❑ Yes	
Did the baby have problems right after birth?	❑ No	❑ Yes	
Were there any problems in the first week of life?	❑ No	❑ Yes	
Did the baby have to stay in the hospital after mother went home?	❑ No	❑ Yes	
Did you use drugs, alcohol or tobacco during your pregnancy?	❑ No	❑ Yes	
Did you have any problems breastfeeding?	❑ No	❑ Yes	
History of breech delivery?	❑ No	❑ Yes	
Did the baby receive hepatitis B immunization prior to discharge?	❑ No	❑ Yes	
Did the baby receive vitamin K shot?	❑ No	❑ Yes	
Did the baby pass the newborn hearing test?	❑ No	❑ Yes	
Did the baby pass the congenital heart disease screen?	❑ No	❑ Yes	

Delivery method? ❑ Vaginal ❑ Cesarean If Cesarean, reason: _____

Birth weight: _____ lbs _____ oz Birth length: _____ inches Gestational age: _____ weeks

MEDICAL HISTORY:

ADD/ADHD	❑	Heart murmur	❑	Pneumonia	❑
Allergies	❑	HIV/AIDS	❑	Scoliosis	❑
Asthma	❑	Inflammatory bowel disease	❑	Seizures	❑
Cancer	❑	Jaundice	❑	Sickle cell anemia	❑
Chronic encephalopathy	❑	Lead poisoning	❑	Strep throat (recurrent)	❑
Diabetes mellitus	❑	Meningitis	❑	UTI	❑
Eczema	❑	Obesity	❑	Varicella	❑
Headaches	❑	Otitis media	❑	Vision problems	❑
Hearing loss	❑	MRSA	❑	Dental problems	❑

Other Medical History: _____

SURGICAL HISTORY:

Adenoidectomy	❑	Ear tubes	❑	Lymph node biopsy	❑
Appendectomy	❑	Gastrostomy	❑	Tonsillectomy	❑
Cleft lip	❑	Heart surgery	❑	Umbilical hernia	❑
Cleft palate	❑	Inguinal hernia	❑	VP shunt	❑
Dental surgery	❑				

Other Surgical History: _____

Patient Identification

FAMILY HISTORY:

Relationship	Name	No Known Problems	Alcohol abuse	Arthritis	Asthma	Birth defects	Cancer	COPD	Depression	Diabetes	Drug abuse	Early death	Hearing loss	Heart disease	High cholesterol	High blood pressure	Kidney disease	Learning disability	Mental illness	Developmental disability	Miscarriages	Stroke	Vision loss	Migraines	Other
Mother																									
Father																									
Brother																									
Brother																									
Sister																									
Sister																									

Was this child adopted? ❑ No ❑ Yes Family history unknown ❑

SOCIAL HISTORY:

Please list all those living in the child's home

Name	Relationship to child	DOB	Health Problems	Occupation

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

If mother and father are not living together, or the child does not live with parents, what is the child's custody status? __

If one or both parents are not living in the home, how often does he/she see the parent/parents not in the home? _____

Has the patient ever used cigarettes or smokeless tobacco? ❑ No ❑ Yes

If yes, quantity per day _____

Does anyone in the home smoke? ❑ No ❑ Yes

Is the patient exposed to passive or "second-hand" smoke? ❑ No ❑ Yes

Any concerns that we should know about your family, your child, your child's social, school or living situation? _____

Patient Identification

PeaceHealth
Medical Group

PEDIATRIC REVIEW OF SYSTEMS

Name of patient: _____ DOB: _____ Today's Date: _____
This questionnaire has been filled out by: _____ Relationship to patient: _____

Please check any of the following that are of concern to you. If no concerns, check here ❑

General
- ❑ Poor appetite
- ❑ Excessive appetite
- ❑ Excessive thirst
- ❑ Overweight
- ❑ Underweight
- ❑ Difficulty sleeping
- ❑ Excessive sleeping
- ❑ Confusion
- ❑ Fever
- ❑ Loss of memory
- ❑ No energy
- ❑ Excessive energy
- ❑ Behavior problems

Skin
- ❑ Rash
- ❑ Acne
- ❑ Unexplained lump
- ❑ Easy bruising
- ❑ Dandruff
- ❑ Itching
- ❑ Birthmarks

Eyes
- ❑ Eye pain
- ❑ Blurred vision
- ❑ Crossed eyes
- ❑ Seen by eye doctor

ENT
- ❑ Earaches
- ❑ Hearing problems
- ❑ Loud snoring
- ❑ Concerns about teeth
- ❑ Congestion/sneezing/itchy eyes

Respiratory
- ❑ Hoarseness
- ❑ Cough
- ❑ Wheezing
- ❑ Difficulty breathing
- ❑ Exercise tolerance

Cardiovascular
- ❑ Chest pain
- ❑ Heart murmur
- ❑ High blood pressure
- ❑ Blue spells
- ❑ Fainting

Gastrointestinal
- ❑ Abdominal pain
- ❑ Nausea
- ❑ Vomiting
- ❑ Pain after eating
- ❑ Hard or painful stools
- ❑ Blood in stool
- ❑ Stool in underwear

Urinary
- ❑ Painful urination
- ❑ Frequent urination
- ❑ Abnormal urine stream
- ❑ Daytime wetting
- ❑ Bed wetting
- ❑ Urine color other than yellow

Skeletal
- ❑ Bone/muscle/joint pain
- ❑ Weakness
- ❑ Back pain
- ❑ Swollen joints
- ❑ Broken bones

Neuromuscular
- ❑ Headache
- ❑ Migraine
- ❑ Numbness
- ❑ Loss of coordination/balance
- ❑ Dizziness
- ❑ Unexplained movement/jerks
- ❑ Seizure
- ❑ Staring spells
- ❑ Concussion
- ❑ Delayed development

If your child is a girl and she has started her menstrual periods, complete the following:
When did she begin? Month: _____ Year: _____ When was her last period? _____
Check any that apply: ❑ Painful/irregular periods ❑ Excessive bleeding ❑ Other _____

_____
Signature Patient/Person Authorized to Sign for Patient – Relationship Date Time

_____
Provider Signature EHR User ID Date Time

Place patient label here

Clinic PN

PeaceHealth

Child TB Screening Questionnaire

Date: _____

	Yes	No
• Was your child born outside the United States? If yes, did your child receive the BCG vaccine? (BCG is a TB vaccine sometimes given in foreign countries)	❑ ❑	❑ ❑
• Has anyone in your household had TB or a positive TB skin test? (Includes your child, extended family, overnight guests, frequent visitors, babysitters, and day care providers)	❑	❑
• Has your child lived outside the United States for more than a month? If so, where? _____	❑	❑
• Has your child ever lived in a homeless shelter?	❑	❑
• Has anyone in your household ever been incarcerated or worked in a jail or prison?	❑	❑

_____

Signature of patient or person authorized to sign for patient – Relationship Date Time

_____

Signature EHR User ID Date Time

Patient Identification

Clinic History

PeaceHealth *Authorization to Use and Disclose Health Information*

Patient

Patient Name: _____ Birth Date: _____ Ph. #: _____

SSN: _____ Address: _____

From / To

I authorize the use and/or disclosure of the health information described below for the above-named patient by the following entities: ***(Complete addresses required in order to process request)***

Information is to be released FROM:	Information is to be disclosed TO:
_____	_____
_____	_____
_____	_____

Please specify the hospital, clinic, or practice holding the records.

_____

_____

_____

Purpose

For the purpose(s) of:

☐ At the request of the patient or legal/personal representative

☐ Other purposes (specify each purpose): _____

Info to be Disclosed

Description of nature of information to be used and/or disclosed: (initial all that apply)

____ Discharge summaries
____ History & Physical exams
____ Consultations
____ Operative reports
____ Physician progress notes
____ Nursing notes
____ Clinician office notes

____ Pathology reports
____ Radiology/imaging reports
____ Laboratory reports
____ EKG reports
____ Emergency Dept. record
____ Medication records
____ Billing statements

Specially Protected Information:
____ Mental health treatment records
____ Drug/Alcohol abuse diagnosis, treatment, and referral records
____ Information re: HIV/AIDS/Sexually transmitted diseases
____ Information re: Genetic testing (Oregon)

____ Other information (specify): _____

____ Records for the following dates or treatment: _____

____ All health records from the above-named entity (Excludes above Specially Protected information unless indicated by initials)

Notices

1. I understand that, if the recipient of the information disclosed under this authorization is not a health plan or provider covered by federal or state privacy laws, the information may be re-disclosed by the recipient and no longer protected by those laws. If the information being disclosed under this authorization includes HIV/AIDS, Sexually Transmitted Diseases, mental health, genetic testing, and drug/alcohol abuse diagnosis, treatment, or referral information, Federal law and regulation including 42 CFR Part 2 and 445 CFR Parts 160 and 164 or state law may prevent the recipient from re-disclosing this information.
2. I may refuse to sign this authorization. My refusal will not adversely affect my ability to receive treatment, to enroll in a health plan, to be eligible for benefits, or to obtain payment for services unless this authorization is sought for purposes of research-related treatment, to determine my eligibility or enrollment in a plan, for underwriting or risk determinations or if the services related to the information to be disclosed are performed solely for the purpose of providing that information to someone else.
3. I may revoke this authorization at any time by notifying the Health Information Management/Medical Records Department of the above-named entity on its designated form. However, any such revocation will not apply to any activity undertaken based on this authorization. PeaceHealth's Joint Notice of Privacy Practices also describes how to revoke this authorization.
4. I received a copy of this authorization. I may inspect or request copies of information disclosed by this authorization.

Dates

Unless revoked, this authorization is valid for 90 days from the signature date below or for the following time period.

Beginning date: _____ Ending (expiration) date: _____

(In Washington state, expiration date can be no later than 1 year after this authorization is signed if disclosure is to employer or financial institution.)

Signature

SIGNATURE: I have read this authorization, and I understand it.

_____ _____ _____

Signature of Patient or personal representative Relationship to patient Date

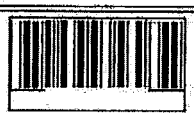
*If the patient's personal representative, you may be required to provide appropriate documentation to demonstrate authority to act on behalf of the patient (Examples of documentation include Power of Attorney, Death Certificate, Court order)

For PeaceHealth Use Only

Date Received: _____ MRUN # _____ Acct # _____ ☐ Identity and authority verified

☐ Fees explained if needed ☐ Records sent by _____ Date/Time: _____

Please don't write in box:



Release of Information Authorization SYS1020 (09/27/18)

White Copy: Med. Record, Yellow Copy: Patient

PeaceHealth

YOUR BILLING RIGHTS

Keep this notice for future use

This notice contains important information about your rights and our responsibilities under the Fair Credit Billing Act.

Notify us in case of errors or questions about your bill.

If your think your bill is wrong, or if you need more information about a transaction on your bill, write us (on a separate sheet) at the address on your bill that is listed after the words "Send inquiries to." Write to us as soon as possible. We must hear from you no later than 60 days after we sent you the first bill on which the error or problem appeared. You can telephone us, but doing so will not preserve your rights.

In your letter, give us the following information:

- Your name and account number
- The dollar amount of the suspected error
- Describe the error and explain, if you can, why you believe there is an error. If you need more information, describe the item you are not sure about.

If you have authorized us to pay your bill automatically from your savings or checking account, you can stop the payment on any amount you think is wrong. To stop the payment, your letter must reach us three business days before the automatic payment is scheduled to occur.

Your rights and our responsibilities after we receive your written notice:

We must acknowledge your letter within 30 days unless we have corrected the error by then. Within 90 days, we must either correct the error or explain why we believe the bill was correct.

After we receive your letter, we cannot try to collect any amount you question or report you as delinquent. We can continue to bill you for the amount you question, including finance charges, and we can apply any unpaid amount against your credit limit. You do not have to pay any questioned amount while we are investigating, but you are still obligated to pay the parts of your bill that are not in question.

If we find that we made a mistake on your bill, you will not have to pay any finance charges related to any questioned amount. If we didn't make a mistake, you may have to pay finance charges, and you will have to make up any missed payments on the questioned amount. In either case, we will send you a statement of the amount you owe and the date it is due.

If you fail to pay the amount that we think you owe, we may report you as delinquent. However, if our explanation does not satisfy you, and you write to us within ten days telling us that you still refuse to pay, we must tell anyone we report you to that you have a question about your bill. And, we must tell you the name of anyone we reported you to. We must tell anyone we report you to that the matter has been settled between us when it finally is.

If we don't follow these rules, we can't collect the first $50 of the questioned amount, even if your bill was correct.

Continued on back

PeaceHealth

Patient Rights and Responsibilities

PeaceHealth patients (or patient representatives, as appropriate) have the right to...

Dignity, respect and compassion. *This includes the right to:*

- Access and receive respectful treatment without regard to age, race, ethnicity, religion, culture, language, disability, socioeconomic status, sex, sexual orientation and gender identity or expression;
- Medical care that preserves personal dignity and respects personal values, beliefs and preferences and addresses psychological, spiritual, social and intellectual needs;
- Receive care in a safe environment that a reasonable person would consider safe and that provides protection for emotional health and physical safety;
- Be free of all forms of abuse, neglect or harassment (verbal, mental, corporal punishment, physical and sexual abuse, financial, exploitation and unnecessary restraints and seclusion).

Quality care. *This includes the right to:*

- Complete information about your diagnosis, treatment and prognosis presented in a way you can reasonably be expected to understand, and participate in the development and implementation of your inpatient or outpatient treatment/care plan;
- Receive all the information necessary to make informed decisions regarding your care, including a full description of the treatment or procedure before the care is rendered unless in an emergent situation; the expected benefits, risks and alternatives to the treatment, including the alternative of no treatment at all, and to request or refuse treatment;
- Receive information about pain management as well as alternative pain management options, when suitable for the condition being treated;
- Receive information regarding unanticipated events and outcomes of care;
- Receive an appropriate emergency medical screening examination, stabilizing treatment and, when needed, transfer to a higher level of care after receiving an explanation concerning the need for, and the alternatives to, such a transfer;
- Consult with another physician at your own request and expense;
- Request a consultation with the facility Ethics Committee.

Safety. *This includes the right to:*

- Caregivers who are free from having been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law;
- Know that, to enhance patient safety, video or auditory monitoring may be done in some individual patient rooms, care areas or common areas.

Meaningful interactions and information. *This includes the right to:*

- Receive reasonable access to language assistance, at no charge;
- Receive communications on important information taking into account: Vision, speech, hearing, or disability;
- Choose a support person to participate in healthcare planning and decision making without being asked to provide proof of a legal relationship;
- Have a physician and family member, or other designated contact person, notified promptly of your admission to the hospital;
- Receive visitors whom you designate, including, but not limited to: A spouse, a domestic partner, a same-sex domestic partner, another family member, or a friend, and to withdraw or deny such designation at any time;
- Be advised and informed of applicable research projects and choose whether to participate in research;
- As a Medicare beneficiary, receive notice of non-coverage and your rights to appeal premature discharge;
- Expect discharge planning for continuing care requirements following release from the hospital;
- Know about any business interests' providers may have in health services to which you may be referred;
- Know about any financial arrangement's providers may have with outside healthcare services.

Personal care. *This includes the right to:*

- Know the names and roles of individuals providing your care and who has primary responsibility for coordinating your care.
- Know which physician or Licensed Independent Practitioner (LIP) is in charge of your hospital care and the names of other clinical personnel involved in care;

PeaceHealth

Temporary Parental Consent Agreement

(Effective only if the parents(s) or Legal Guardian is not readily available)

1. TEMPORARY CONSENT

I/We, _____ residing in _____
(name of parent(s) or legal guardian) ("Parent(s)") (County)
designate _____ to temporarily care as indicated below for
(name(s) and relationship) ("Designee")
_____ over whom I/we have legal custody and guardianship.
(name of child) ("Child")

In case Child requires health care treatment or health care coordination, designee shall have the power to do the following:

a. Arrange for suitable transport to and from the clinic, hospital or in-patient settings;
b. Accept discharge planning instructions at the time Child is discharged from hospital or clinic care;
c. Make determinations regarding the appropriate health care setting for Child, including but not limited to dealing with attending physicians, which course of treatment is necessary or desirable, and coordinating follow-up care;
d. Consent to necessary health care, including but not limited to emergent and non-emergent medical and dental care, early periodic screening, and immunizations; and;
e. Request the medical records of Child for continued care.

Parent(s) contact information during the time this Agreement is in effect is:

Phone: _____

Email: _____

Address: _____

2. RELEASE

Parent(s) authorize PeaceHealth to discharge Child into the care of Designee. Parent(s) acknowledge that this Agreement is voluntary and hereby release Hospital/Clinic from any, and all liabilities related to or arising out of the authority granted to Designee in this Agreement.

3. DURATION

This Agreement is effective upon signing and shall remain in effect for 6 months or until I/we, as Parent(s), revoke this Agreement, whichever comes first. Either parent may, subject to any

current court order or parenting plan, initiate or revoke this consent and end this agreement at any time by delivering to PeaceHealth a signed, written notice.

Signature of patient or person authorized to sign for patient – Relationship Date Time

Printed Signature of patient or person authorized to sign for patient

Date of Expired OR Date Revoked
(unless revoked, the consent is valid 6 months from the signature date)

Caregiver Signature (Witness) EHR User ID Date Time

Caregiver Signature (Witness) EHR User ID Date Time

OR

Notary