

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



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
		.....		
		SIBLING:	AGE:	HEALTHY: Y    N
SIBLING:		AGE:	HEALTHY: Y    N	
SIBLING:		AGE:	HEALTHY: Y    N	
SIBLING:		AGE:	HEALTHY: Y    N	
.....				
S		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: \_\_\_\_\_



## Developmental Drawing Sheet

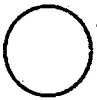
Please use this sheet to allow your child to show us their creativity. This is not only fun for your child, but also allows us to observe fine motor and cognitive skills. Several age groups are listed. Find your child's age and ask them to complete the activities for that age. Remember to allow your child to practice these skills with you at home. Coloring is fun and great for your child's brain development. When you are done, draw a picture on the back of the page.

15 Months- 30 Months Old:

Let your child use your pen and clipboard to have fun and scribble in the space below.

3 & 4 Years Old:

Ask your child to copy the circle and cross pictured below & draw a person.



5 Years Old:

Ask your child to draw a circle and cross, copy the square and triangle pictured below, print some letters and numbers, & draw a person.

CIRCLE:

CROSS:



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Draw us a picture below