Initial History Questionnaire

Form Completed By:	Name:		
Date:	ID Number:		
Phone Number:	Birth Date:	Age:	Sex: M F

GENERAL

Do you consider your child to be in good health? □ Yes □ No □ Don't know Explain: _____

Does your child have any special health care needs? □ Yes □ No □ Don't know Explain: _____

Has your child ever been hospitalized? □ Yes □ No □ Don't know Explain: _____

Is your child allergic to medicine or drugs? □ Yes □ No □ Don't know Explain: _____

SOCIAL HISTORY

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

Name	Relationship to Child	Birth Date/Age

Please list other siblings not living in the home.

Name	Birth Date/Age	Where are they living?

Does the child live with both biological parents? □ Yes □ No

If no, what is the child's current living situation?

□ Single-parent custody □ Joint custody □ Adoptive family

□ Other family members: _____ □ Foster care

How often does the child have visitation with parent(s) not living in the home?

BIRTH HISTORY

Birth weight: _____

□ Full-term □ Preterm _____ weeks □ Post-term _____ weeks

Delivery: □ Vaginal □ Cesarean □ Reason: _____

Any complications during birth or after birth? □ No □ Yes

Explain: _____

Did the baby need to go to the NICU (neonatal intensive care unit)?

□ No □ Yes Explain: _____

During pregnancy, did the mother:

Take prenatal vitamins?	□ Yes	□ No	□ Unknown
Smoke or use e-cigarettes?	□ Yes	□ No	□ Unknown
Drink alcohol?	□ Yes	□ No	□ Unknown
Use marijuana?	□ Yes	□ No	□ Unknown
Use illicit drugs?	□ Yes	□ No	□ Unknown
Take other medications?	□ Yes	□ No	□ Unknown

If yes, please list:

Blood type:

Mother: _____ □ Unknown

Baby: _____ □ Unknown

Mother's lab results:

Hepatitis B	□ Pos	□ Neg	□ Unknown
HIV	□ Pos	□ Neg	□ Unknown
Group B streptococcus (GBS)	□ Pos	□ Neg	□ Unknown

After birth, did the baby get:

Vitamin K shot?	□ Yes	□ No	□ Unknown
Erythromycin eye ointment?	□ Yes	□ No	□ Unknown
Hepatitis B shot?	□ Yes	□ No	□ Unknown

How was the baby fed? □ Bottle formula □ Bottle breast milk

□ Breastfed How long was baby breastfed? _____

Did baby go home with biological mother from hospital after birth? □ Yes

□ No Explain: _____

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®

TO

HE0564

Initial History Questionnaire

Name: _____

PAST MEDICAL HISTORY

Has your child ever had any of the following problems? DK = Don't know

Condition	DK	No	Yes	Details
Eye problems, cataracts, or retinoblastoma				
Vision impairment or concerns				
Nasal allergies (dust, pets, or environmental)				
Frequent ear infections				
Hearing loss or concerns				
Multiple cavities or problems with teeth				
Frequent colds or sore throats				
Asthma, wheezing, or breathing problems				
Bronchitis, bronchiolitis, or pneumonia				
Heart murmur or other heart problems				
High blood pressure				
Frequent stomach pain				
Constipation needing medical treatment				
Food allergies or intolerance (eg, milk, gluten)				
Feeding issues or underweight				
Overweight or obesity				
Urinary tract infections				
Bed-wetting (after 5 years old)				
Kidney, ureter, or bladder problems				
Serious injuries or fractures				
Bone, joint, or muscle problems				
Frequent headaches or dizziness				
Concussion or head injury				
Convulsions, seizures, or neurological issues				
Sleep problems or snoring				
Skin rashes, eczema, or hives				
Acne				
Thyroid or other endocrine problems				
Diabetes				
Metabolic/genetic disorders				
Anemia or bleeding problems				
Cancer or chemotherapy				
Bone marrow or organ transplant				

Name: _____

PAST MEDICAL HISTORY *(continued)*

Has your child ever had any of the following problems? DK = Don't know

Condition	DK	No	Yes	Details
Blood transfusion				
HIV or AIDS				
Chickenpox or zoster (shingles)				
Developmental delays (speech or motor)				
School problems or learning difficulties				
ADHD or behavioral concerns				
Anxiety, depression, or mood problems				
Tobacco, alcohol, or drug use				
Exposure to family violence				
Pregnancy or miscarriage				
Sexually transmitted infections				
Females: issues with periods				
Age of first period:				

Other medical problems (Please list.)

SURGICAL HISTORY

Has your child ever had surgery? ☐ No ☐ Yes If yes, please provide details below.

Surgery/Procedure	Date of Surgery/Child's Age	Where Completed	Details

Other surgical/procedural problems (Please list.)

Medications (Please list)

Initial History Questionnaire

Name: _____

FAMILY HISTORY

Have any of your child's parents, grandparents, aunts, uncles, brothers, or sisters ever had any of the following conditions? DK = Don't know

Condition	DK	No	Yes	Who?	Details
Anemia or bleeding problems					
Asthma					
Allergies					
Alcohol use problems					
Bed-wetting (after age 10 years)					
Cancer (before age 55 years)					
Childhood hearing loss					
Dental decay or multiple cavities					
Depression or anxiety					
Developmental disability					
Diabetes					
Heart attack (myocardial infarction)					
Heart disease (before age 55 years)					
High blood pressure					
High cholesterol					
HIV or AIDS					
Kidney disease					
Liver disease					
Mental health conditions					
Obesity					
Seizures or epilepsy					
Stroke					
Substance use problems					
Sudden death (before age 50 years)					
Thyroid or other endocrine disease					
Tobacco use problems					
Tuberculosis					
Vision or eye problems					

Other medical problems (Please list.)

PRINT NAME.	SIGNATURE/DATE/TIME
Provider 1	
Provider 2	

Consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents,* 4th Edition

Prev Provider:

GRAND LAKE™ HEALTH SYSTEM
200 St. Clair Street
St. Marys, Ohio 45885
(419) 394-3335

PATIENT REQUEST FOR ACCESS TO HEALTH INFORMATION

GLHS recognizes a patient's right of access under HIPAA.

Patient Name: _____ Patient Date of Birth: _____

1. Request access for Dates of Service:_____
   OR ☐ Any and All Past, Present and Future information (until revoked in writing)

2. Information to be accessed or released: (check ONLY ONE box below)
   ☐ ALL Grand Lake Health System Records: Joint Township District Memorial Hospital (JTDMH) and all Physician Practice records
   ☐ Joint Township District Memorial Hospital records ONLY (this includes ER, Inpatient, Urgent Care, Outpatient testing, Outpatient Services, Rehab/Therapy, Outpatient Clinics (Pain/Sleep/IV, etc)
   ☐ ONLY specific portions of the JTMDH record:
   - ☐ Discharge Summary
   - ☐ History & Physical
   - ☐ Consultation
   - ☐ Operative Report
   - ☐ Discharge Instruction Sheet
   - ☐ ER Chart
   - ☐ Urgent Care Chart
   - ☐ Laboratory Reports
   - ☐ Medical Imaging Reports/CD Images
   - ☐ EKG
   - ☐ Physician Orders
   - ☐ Progress Notes
   - ☐ All Dictated Reports
   - ☐ Other (specify): _____

   ☐ ALL Grand Lake Physician Practice Records (ALL Offices, including family practice and specialty)
   ☐ ONLY records from specificPhysician Practice Office; Office Name:_____

3. Requestor: (check one)☐ Self (Patient) ☐ Patient Representative; Name _____
   IF Patient Representative, check one below AND validate parent OR documents
   ☐Parent/Guardian ☐HPOA ☐Executor of Estate ☐Other: _____

4. How would you like record copies delivered? (check all that apply)
   ☐ Paper Copy ☐ Electronic Copy via USB/Flash Drive (ONLY on device supplied by GLHS)
   - ☐ In-Person Pickup (self)
   - ☐ Allow someone else to pick up my records; Name: _____
   - ☐ Mail Delivery; Street Address: _____
     City/State/Zip: _____

   ☐ Email Copy; email address: _____ * NOTE: EMAIL is NOT a secure method of sending medical information. I understand I am requesting my information to be sent in a non-secure method. _____ (patient initials)

   ☐ Fax copies to Patient (Note: Confirm with patient that their fax machine is in a secure location) (GLHS is not responsible for unauthorized disclosure as a result of an unsecured patient fax machine). Patient Initials _____

   ☐ Release Lab Results over the phone. Please provide a password _____ (GLHS is not responsible for unauthorized disclosure as a result of someone other than the patient calling to receive Lab Results over the phone with above identified password). Patient Initials _____

_____ _____
Signature of Patient or Representative Date

For Internal use only:

Patient MRN #:	Patient Visit #:	
Date Requested:	Date Completed:	Completed By:

GRAND LAKE PEDIATRICS™
AN AFFILIATE OF GRAND LAKE HEALTH SYSTEM

Grand Lake Pediatrics
1010 Hager Street, St Marys, Ohio 45885
Phone: 419. 394. 9579 * Fax: 419. 394. 9580

Patient Name: _____

Consent for Notification

1. If we call you at home and you are not available, may we leave information such as positive/negative test results, appointments, billing matters and health care information with another person?

   _____YES _____NO

   If YES, please state name of person (s) and relationship:

   Name _____ Relationship _____

   Name _____ Relationship _____

   Name _____ Relationship _____

2. If you have an answering machine at home, may we leave a message regarding positive/negative test results, appointments, billing matters and health care information? Please note: If your answering machine does not identify yourself, we will not leave a detailed message.

   _____YES _____NO

3. If you have a cell phone may we leave a message regarding positive/negative test results, appointments, billing matters and health care information? Please note: If your cell phone voice mail does not identify yourself, we will not leave a detailed message.
   ** I am fully aware that a cellular telephone is not a secure line and private line.

   _____YES _____NO

If the above answers are NO, how is the best way to contact you? _____

_____
Please PRINT Name

_____ _____ _____
Date of Birth Signature of Patient or Legal Representative Date

If signed by legal representative, relationship to patient:_____

This Authorization is valid until you inform our office otherwise in writing.

GRAND LAKE
PHYSICIAN PRACTICES
AN AFFILIATE OF GRAND LAKE HEALTH SYSTEM

Authorization for Proxy Consent for Non-Urgent Pediatric Care

This form must be signed by the child's parent/guardian. By signing this form you authorize another adult to give consent for medical treatment of your child. Please read this form carefully.

This form is used to authorize an adult who is not the child's parent/guardian to consent to medical treatment for the child at _____ [*name of office/department*] ("Provider") in the absence of the parent/guardian and to allow Provider to release medical information about the child to the person providing proxy consent as necessary.

Name of Child: _____ Date of Birth: _____

☐ I **want** to be notified prior to any medical treatment such as immunizations, injections, or procedures. (Your child will Not receive treatment if you can't be reached/notified.)

☐ I give my proxy consent and do **not** want to be notified prior to any medical treatment such as immunizations, injections, or procedures.

Printed name of parent/guardian: _____

Statement of authorization by the parent/guardian: I hereby authorize the person(s) listed below to consent to medical treatment for my child, identified above, in my absence pursuant to Ohio Revised Code 2317.54(C)(2). I understand that as the parent/guardian I remain responsible for the costs of all treatment of my child even if consent is provided by a proxy. I understand that I may revoke this authorization at any time by providing written notice to: _____. In the event that the nature of the medical care requiring consent is not routine, the office may attempt to contact me but if unable to reach me you may rely on the proxy decision maker for consent. I understand that it may be necessary to disclose my child's protected health information to the person providing proxy consent and I hereby authorize Provider to disclose information for such treatment purposes.

Name of Adult Who May Give Consent in My Absence: _____
This Person's Relationship to Child: _____
This Person's Telephone Number: _____

Name of Adult Who May Give Consent in My Absence: _____
This Person's Relationship to Child: _____
This Person's Telephone Number: _____

I have read and I understand this Authorization for Proxy Consent Form and I authorize proxy consent for my child as described above.

This consent will remain in effect for one (1) year from the date of the signature unless otherwise stated below.

This consent is to remain in effect until _____, 20____.

_____ _____
Parent/Guardian Signature Date/Time

_____ _____
Parent/Guardian Printed Name Telephone Number of Parent

_____ _____ _____
Witness / Printed Name Witness Signature Date/Time

GRAND LAKE
PHYSICIAN PRACTICES™
AN AFFILIATE OF GRAND LAKE HEALTH SYSTEM

Consent for Medical Treatment and Disclosure of Information

Patient Name: _____
Last First Middle

Patient's Date of Birth: _____

Authorization for Treatment: I hereby consent to the medical care recommended by my health care providers at Grand Lake Physician Practice. I authorize payment for all medical benefits for services performed at Grand Lake Physician Practice (GLPP).

Photographs, Videos: I understand that photographs, videotapes, digital or other images may be recorded to document my care, and I consent to this. I understand that GLPP will retain the ownership rights to these images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or outlined in policy. I also understand that several patient care areas have in-room surveillance to monitor patients for safety. Images that identify me will only be released and/or used outside the GLPP upon receipt of written authorization from me, or my legal representative.

Use and Disclosure of Information:
I consent to the use and disclosure of information from my medical record, including protected health information, by GLPP for treatment, payment, and health care operations as permitted by law. All uses and disclosures will abide by the terms identified in the GLHS Notice of Privacy Practices.

Prescription Drug Dispense History, Price and Benefit Information: I consent to my health care provider pulling my medication dispense history via a secure Surescripts database embedded in the electronic medical record. I understand that Surescripts utilizes patient information to retrieve medication dispense history data, which assists with timely and efficient patient centered care. I also consent to my health care provider to access and compare prescription price and benefit information. _____ Initials

Medicare and/or CHAMPUS/CHAMPVA Patients: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration, its Intermediaries, or Carriers any information needed for this claim or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for services to the practitioner or organization furnishing the services, or authorize such practitioner or organization to submit a claim to Medicare for payment.

PATIENT RIGHTS AND RESPONSIBILITIES

Notice of Privacy Practice: I hereby acknowledge that I have received Grand Lake Health System's notice of privacy practices, which sets forth the ways in which my personal health information may be used or disclosed, and outlines my rights with respect to such information. GLPP is required to provide each patient one copy of our notice of privacy practices as well as any subsequent revision to the notice.

GRAND LAKE™ HEALTH SYSTEM

Patient Portal Account Access Form

Thank you for your interest in the FollowMyHealth patient portal, made available by Grand Lake Health, to provide a convenient and secure way for patients to manage their personal health record from any computer or mobile device with internet access.

Instructions for Completing this Form

To sign up for access to your health information in FollowMyHealth, please complete this Access Form. You will receive an email with an invitation to join FollowMyHealth and step by step instructions to complete the process. A separate form will need completed for each patient requesting/granting access.

Your Information: (All sections required in order to receive an invitation – please print clearly.)

Patient Name: _____ Patient Birth Date ____/____/____ Sex: M □ F□

Patient Address: _____
(Street) (City) (State) (Zip Code)

Patient Phone:_____ Patient Email: _____

ACCESS TYPE
□ **Minor child Proxy (age 13 or younger)** – must have authorization signed by parent/legal guardian
□ **Minor child Proxy (age 14 to 17)** – must have authorization signed by patient (minor patient) • **for parent or legal guardian** □ **I grant full access** □ **I grant the standard limited access**
□ **Minor personal access (age 14 to 17)** – must have authorization signed by patient (minor patient) • **for patient's personal access**
□ **Adult Proxy (age 18+)** – must have authorization signed by patient • **for adult to grant another individual full access to their portal**
□ **Adult Personal Access (age 18+)** – Simply provide email address at time of check-in/registration – OR have authorization signed by patient.
To have access granted to the patient portal return this Patient Portal Account Access Form to one of the following: Grand Lake physician practice, medical records department at JTDMH or fax to 419-394-3692

INFORMATION FOR PROXY REQUESTING ACCESS (Proxy access is providing access to your patient information on the FollowMyHealth patient portal to someone other than yourself)

Proxy Name: _____ Proxy Birth Date ____/____/____

Proxy Address: _____
(Street) (City) (State) (Zip Code)

Proxy Phone:_____ Proxy Email: _____

Relationship to Patient: □ Mother □ Father □ Spouse □ Guardian □ POA □ Attorney □ Other

AUTHORIZATION: Permission is hereby granted to Grand Lake Health to release medical information via the Grand Lake Health FollowMyHealth® Patient Portal, to the individual as identified above.

Responsible Party Signature: _____ Date:_____

Relationship to patient: □ Self □:_____

FOR INTERNAL USE ONLY

□ Reviewed and verified form. _____ initials Patient MRN:_____

□ Access initiated in EHR_____ initials □ Form sent for scanning into EHR _____ initials

GRAND LAKE
HEALTH SYSTEM

PATIENT INFORMATION

HOW DID YOU HEAR ABOUT US? _____

SOCIAL SECURITY # _____

FIRST NAME _____ MIDDLE _____

LAST NAME _____

SEX _____ DATE OF BIRTH ___/___/_____ RACE _____

PREFERRED LANG. ☐ ENG. OTHER _____ ETHNICITY _____

MARITAL STATUS ☐ MARRIED ☐ SINGLE

☐ DIVORCED ☐ WIDOWED ☐ LEGALLY SEPARATED

E-MAIL _____

HOME ADDRESS _____

_____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____

CELL PHONE _____

WORK PHONE _____

EMPLOYER/OCCUPATION _____

REFERRING PHYSICIAN _____

FAMILY DOCTOR _____

EMERGENCY CONTACT

NAME _____ HOME PHONE _____

RELATIONSHIP WORK PHONE _____

IF MARRIED, SPOUSE INFORMATION

NAME _____ DATE OF BIRTH ___/___/_____ SSN _____

EMPLOYER _____ WORK PHONE _____

IF MINOR (UNDER THE AGE OF 18) WHO IS FINANCIALLY RESPONSIBLE? ☐ MOTHER ☐ FATHER

MOTHER'S NAME _____

ADDRESS _____

_____

SSN _____ DOB _____/_____/_____

EMPLOYER _____

WORK PHONE _____ CELL PHONE _____

FATHER'S NAME _____

ADDRESS _____

_____

SSN _____ DOB _____/_____/_____

EMPLOYER _____

WORK PHONE _____ CELL PHONE _____

INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

☐ Medicaid ☐ Medicare ☐ None ☐ Other

INSURED'S NAME _____

DATE OF BIRTH ___/___/____ SSN _____

INSURANCE COMPANY _____

RELATIONSHIP _____

CO-PAY _____ POLICY NUMBER _____

SECONDARY INSURANCE INFORMATION

☐ Medicaid ☐ Medicare ☐ None ☐ Other

INSURED'S NAME _____

DATE OF BIRTH ___/___/____ SSN _____

INSURANCE COMPANY _____

RELATIONSHIP _____

CO-PAY _____ POLICY NUMBER _____

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. THE PATIENT IS RESPONSIBLE FOR FEES REGARDLESS OF INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESSS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE PHYSICIAN OF THE SURGICAL AND/OR MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR HIS/HER SERVICES AS DESCRIBED, REALIZING I AM RESPONSIBLE TO PAY NON-COVERED SERVICES. I HEREBY AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY TREATMENT NECESSARY TO PROCESS INSURANCE CLAIMS.

The patient or representative, recognizing the need of medical care and/or evaluation, consents to services as ordered by the attending physician including local anesthesia, laboratory procedures, medical treatment, minor or emergency surgical treatment, radiology procedures, physical examination, or other services rendered under the general and specific instructions of the physician.

_____

SIGNATURE (Patient or Parent if Minor) DATE