WESTSIDE PEDIATRIC GROUP, LLP

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PATIENT INFORMATION SHEET

		TODA	AY'S DATE/
PATIENTLAST	FIRST		PREFER TO BE CALLED
DATE OF BIRTH	_SEXPHO	NE	CELL/LANDLINE
MAILING ADDRESS			
CITY	STATE	ZIP	
PROVIDE ANY CURRENT CUSTODY ORDE	RS (IF APPLICABLE)		
RACE/ETHNICITY SELECT ALL THAT AP	PLY	-	PATIENT PRIMARILY LIVES WITH:
☐ American Indian/Alaskan Native☐ Asian☐ Black/African American☐ White	□ Native Hawaiian/Pad □ Decline □ Hispanic/Latin/Span		BOTH PARENTS MOTHER FATHER GUARDIAN GRANDPARENT FOSTER PARENT
	NO HIPAA (PRIVACY N ATE CONTACTS, LISTED BELOV JTOMATICALLY CONSIDERED A	V (STEP-PARENT, GRAND	
NAME	RELATIONSHIP	PHONE	<u> </u>
ADDRESS		CITY	ZIP
NAME	RELATIONSHIP	PHONE	<u> </u>
ADDRESS			
NAME	RELATIONSHIP	PHONE	:
ADDRESS			
		APPOINTMENT INFORM	ATION / MEDICAL INFORMATION
MAY WE LEAVE A MESSAGE ON HOME PHONE? (Including auto call) MAY WE LEAVE A MESSAGE ON CELL PHONE? (Including auto call) MAY WE SEND TEXT MESSAGES ON CELL PHONE? (Including auto call) MAY WE LEAVE A MESSAGE ON OFFICE VOICE? MAY WE LEAVE A MESSAGE WITH ANOTHER PERSON SEND INFORMATION VIA REGULAR MAIL? SEND INFORMATION VIA E-MAIL/PATIENT PORTAL?		YES/NO YES/NO YES/NO YES/NO YES/NO YES/NO	YES / NO YES / NO YES / NO YES / NO YES / NO YES / NO YES / NO

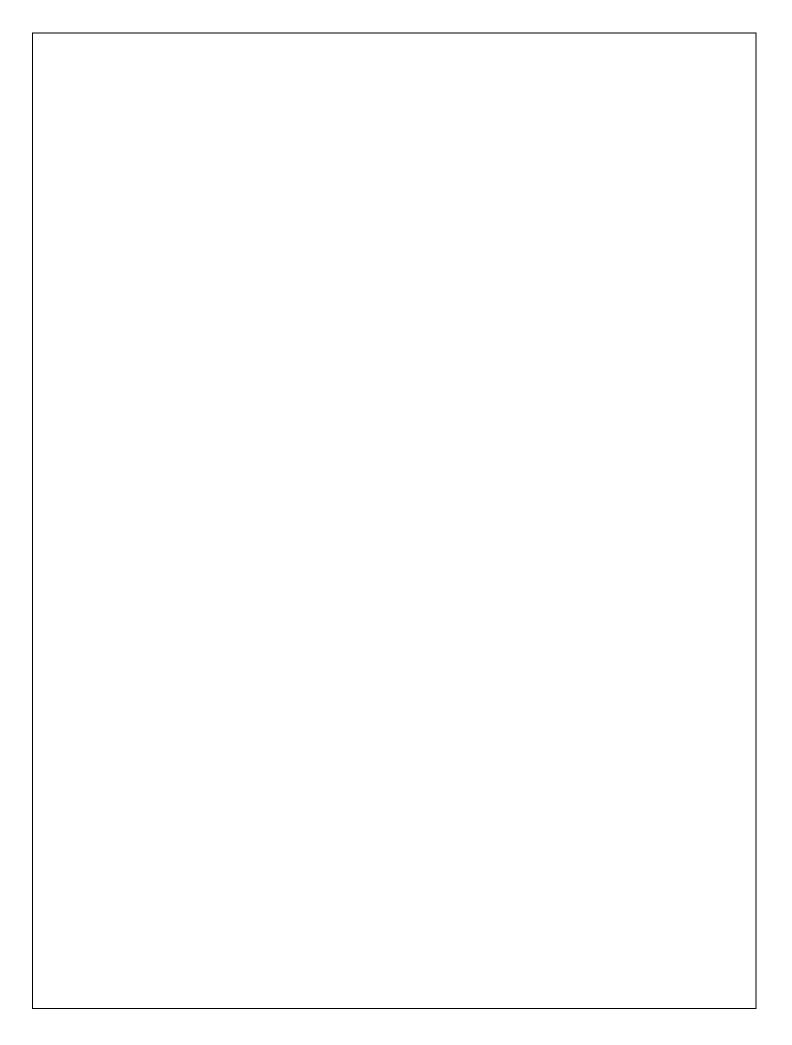
MOTHER/LEGAL GUARDIAN'S INFOR	MATION		
NAME			
LAST DATE OF BIRTH RACE	FIRST PHONE		PREFER TO BE CALLEDCELL/LANDLINE
ALTERNATE PHONE	WORK/OTHER		
MAILING ADDRESS(if different than patient)			
CITY	STATE		ZIP
EMPLOYER			
EMAIL (to be web enabled)			
FATHER/LEGAL GUARDIAN'S INFORM			
NAMELAST	FIRST		
DATE OF BIRTH RACE	PHONE		CELL/LANDLINE
ALTERNATE PHONE	·		
MAILING ADDRESS (if different than patient)			
CITY			ZIP
EMAIL			
EMPLOYER			ECK OFF ANY OF THE AREAS YOU
WOULD LIKE TO SPEAK WITH SOMEONE ABO	UT ANY OF THESE ISSUES:		
FOOD INSECURITYHOUSING PRO	BLEMSTRANSPORTATION ISSU	ESCO	NCERNS WITH HEALTH INSURANCE
ELECTRONIC SIGNATURES WILL BE CAF THE INFORMATION ABOVE AND THE STA		ILD'S OFFIC	E APPOINTMENT, VERIFYING
NSURANCE-AUTHORIZATION TO PAY BENEFITS NOT VALID OR THE SERIVCE/IMMUNZATION IS DENIED FINANCIAL AGREEMENT, WHICH IS AVAILABLE TO YOU	OR NOT COVERED BY YOUR ISURANCE YOU WI		
PAYMENT AGREEMENT: WESTSIDE PEDIATRICS \	WILL USE ANY/ALL PHONE NUMBERS LISTE	ED TO CONTAC	T YOU IN REGARD TO ACCOUNT

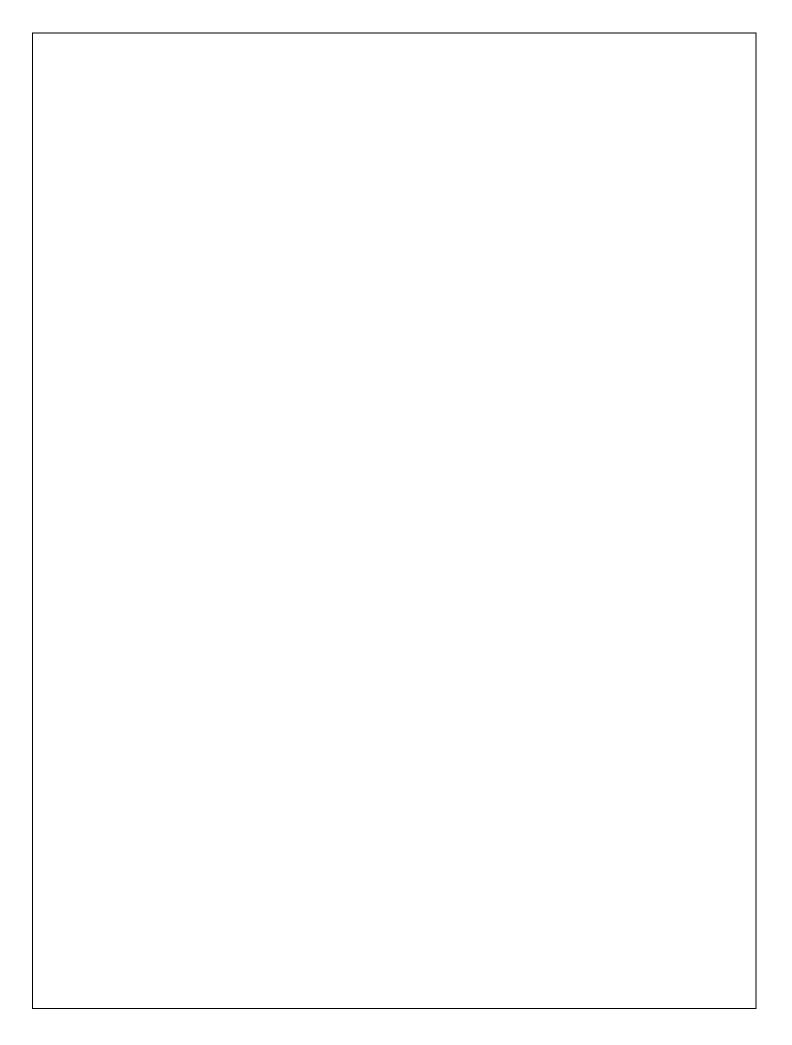
BALANCES, INCLUDING CELL PHONE NUMBERS.

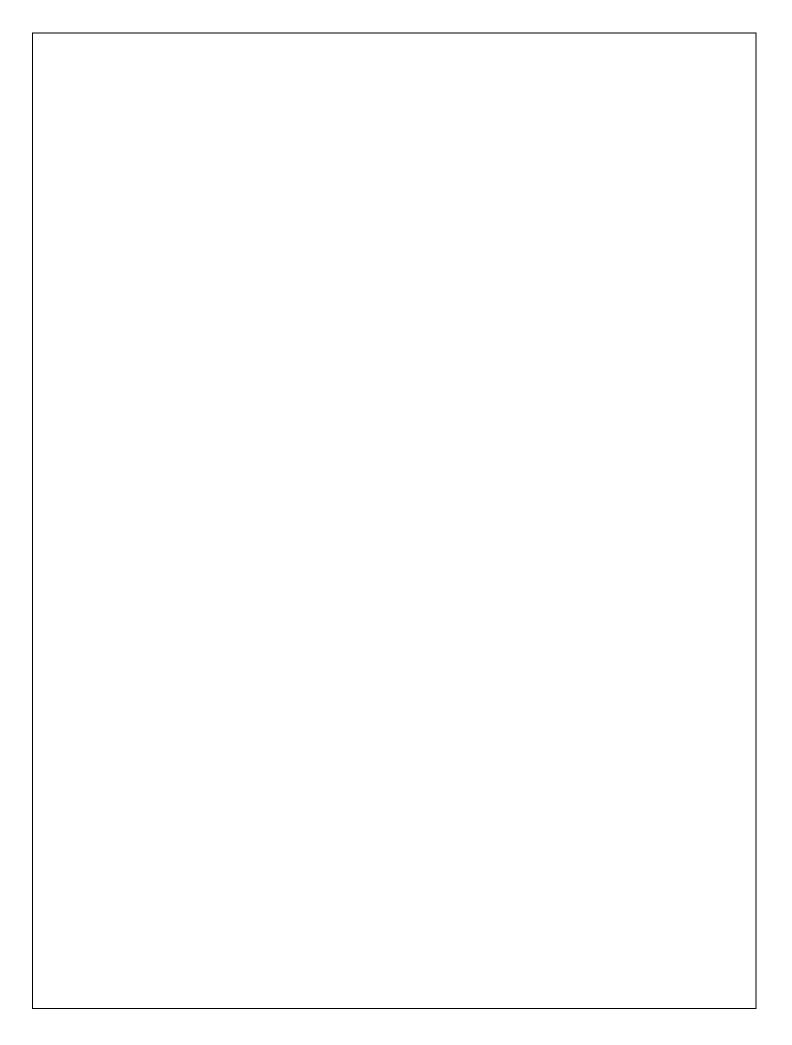
INSURANCE-RELEASE: I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS, AND THE RELEASE OF THE INFORMATION BAK TO MY PHYSICIAN. I ALSO AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE ABOVE STATED PHYSICIAN(S) FOR SERVICES RENDERED.

PRIVACY POLICY: I ACKNOWLEDGE THAT I HAVE BEEN OFFERED A COPY OF THE PRACTICE'S PRIVACY NOTICE AND IF I SO CHOOSE, A COPY WILL BE GIVEN TO ME. (Copies are available in the waiting areas and on our website.)

UPDATED 9/5/2018







Initial History Questionnaire Patient Name Form Completed by /Relationship to patient **Date Completed** Household Please list all adults and children living in the child's home. Name Relationship to **Birth Date** Notes Child Are there any adults or siblings not listed? If so, please list their names, date of birth, relationship to the child and where they live. Birth History Birth weight ___ Was the baby born at term? _____ Early? ____ Late? ____ Was the delivery □ Vaginal □Caesarean If early, how many weeks' gestation? ____ If Caesarean, why? ____ Did mother have any illnesses or problems with her pregnancy? Did your baby have any problems right after birth? ☐ Yes ☐ No Explain ☐ Yes ☐ No Explain _ During pregnancy, did mother: Was initial feeding ☐ Breast ☐ Bottle Smoke Yes No Drink Alcohol Yes No Did your baby go home with mother from the hospital? ☐ Yes ☐ No Explain Use drugs or medications \square Yes \square No ___ When _ What General Has your child had any broken bones, serious injuries, concussion? ☐ Yes ■ No Explain: Does your child have any serious illness or medical condition? Yes □ No Explain: Has your child had any Emergency Room visits? ☐ Yes □ No Explain: Has your child had any operations or been hospitalized? Yes □ No Explain: Does your child take any medications or supplements? ☐ Yes ☐ No Explain: Is your child allergic to any medicines, foods, bee stings, cats/dogs? ☐ Yes □ No Explain: Development Are you concerned about your child's physical development? Yes □ No Explain: □ No Yes Explain: Are you concerned about your child's mental or emotional development? ☐ Yes □ No Explain:

Are you concerned about your child's attention span?

Has he/she failed or repeated a grade in school? _

Is he/she in a special or resource classes? ___

Are you concerned about your child's school performance?

How is he/she doing in academic subjects?

If your child is in school:

How is his/her behavior in school? __

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Family History

Did/Do you or any of the child's relatives have any of the following? (If YES, please identify relative)	Mother	Father	Siblings	Father's Parents	Mother's Parents
Allergies					
Asthma/Wheezing					
Cardiac (heart) problems					
Fainting					
Sudden Death (before age 60)					
Stroke/Blood Clots					
High cholesterol					
High Blood Pressure					
Diabetes					
Obesity					
Bleeding Tendency					
Cancer (Please specify type)					
Scoliosis Scoliosis					
Dev Hip Dysplasia					
Eczema or Psoriasis					
Arthritis					
Thyroid					
Stomach or Intestinal problems					
Kidney/Renal disease					
Migraines					
Seizures					
Hearing Loss					
Vision problems					
Mental retardation					
Developmental delays					
Autism					
Sleep Disorder					
School problem					
Learning disability					
ADHD					
Depression					
Anxiety or OCD					
Bipolar disorder/psychiatric problems					
Alcoholism, drug use/addiction					
Genetic (cystic fibrosis, hemophilia, Marfan syndrome,					
Leiden V mutation, neurofibromatosis etc.					
Birth Defects					
Reaction to dyes or anesthesia					
Chemical exposure (military or job related)					
Immune problems, HIV or AIDS					

Learning disability					
ADHD					
Depression					
Anxiety or OCD					
Bipolar disorder/psychiatric problems					
Alcoholism, drug use/addiction					
Genetic (cystic fibrosis, hemophilia, Marfan syndrome, Leiden V mutation, neurofibromatosis etc.					
Birth Defects					
Reaction to dyes or anesthesia					
Chemical exposure (military or job related)					
Immune problems, HIV or AIDS					
ome type: House Apartment Mobile Home eating: Forced Air Hot Water/Radiator Wood/Pellet St	tove Other				
rinking Water: Village Well Bottled					
louride in drinking water? Yes No Unsure					
oes your child spend time in a home built before 1970 or on	e recently remode	eled? Yes No			
re there guns in the Home ? Yes No If Yes how are they stored					
ny Pets? Yes No If Yes please list					
ny cigarette smokers? Yes No If yes please list					
re you experiencing any family or financial problems? Yes/	No				

Child's History

Does your child have, or has he/she ever had:

Chickenpox	☐ Yes	□ No	When
Frequent ear infections	☐ Yes	□ No	Explain
Problems with ears or hearing	□ Yes	□ No	Explain
Nasal allergies	☐ Yes	□ No	Explain
Problems with eyes or vision	☐ Yes	□ No	Explain
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes	□ No	Explain
Any heart problem or heart murmur	☐ Yes	□ No	Explain
Anemia or bleeding problem	☐ Yes	□ No	Explain
Blood transfusion	☐ Yes	□ No	Explain
Frequent abdominal pain	☐ Yes	□ No	Explain
Constipation requiring doctor's visits	☐ Yes	□ No	Explain
Bladder / kidney infection	☐ Yes	□ No	Explain
Bed-wetting (after 5years old)	☐ Yes	□ No	Explain
(For girls) Has she started her menstrual periods?	☐ Yes	□ No	Explain
, ,			•
(For girls) Are there problems with her period?	☐ Yes	□ No	Explain
Any chronic or recurrent skin problem	Yes	□ No	Explain
(acne, eczema, etc.)			Explain
Frequent headaches	☐ Yes	□ No	Explain
Convulsions or other neurological problem	☐ Yes	□ No	Explain
Diabetes	☐ Yes	□ No	Explain
Thyroid or other endocrine problem	☐ Yes	□ No	Explain
Any other significant problem	☐ Yes	□ No	Explain
Use of alcohol or drugs	☐ Yes	□ No	Explain