Northwest PRIMARY CARE

Pediatric Medical History Form

Legal Name: _____ DOB: _____ Date: _____

Preferred Name (if different than above): _____

Who lives in child's household?
Any other adults involved in the child's care?
Medication Allergies/Intolerances: (list the reaction that occurs)

Personal Medical History: Circle Yes or No, explain yes answers (when occurred or was diagnosed)		
Abdominal Pain	Y	N
Abuse: Physical/Mental/Sexual (circle)	Y	N
Acne	Y	N
ADD/ADHD	Y	N
Allergies	Y	N
Anemia	Y	N
Anxiety Disorder	Y	N
Arthritis	Y	N
Asthma	Y	N
Bleeding Disorder	Y	N
Bronchiolitis	Y	N
Cancer	Y	N
Chicken Pox	Y	N
Concussion	Y	N
Congenital Heart Disease	Y	N
Constipation	Y	N
Depression	Y	N
Diabetes	Y	N
Eczema	Y	N
Fracture	Y	N
GE Reflux/Heartburn	Y	N
Headaches	Y	N
Hearing Problems	Y	N
Heart Murmur	Y	N
High Blood Pressure	Y	N
Kidney Infection	Y	N
Menstrual Problems (females)	Y	N
Migraines	Y	N
Pneumonia	Y	N
Prematurity	Y	N
Recurrent Ear Infections	Y	N
Seizure Disorder	Y	N
Sleep Problems	Y	N
Urinary Tract Infection	Y	N
Other Serious Illness	Y	N

Please list all operations or hospitalizations, including year:

Adopted?	Y	N
Foster Child?	Y	N

Family History (Blood Relatives)	**Age at Death**	If living, list any health problems (heart disease, cancer, diabetes, high blood pressure, etc.). If deceased, cause of death.
Father		
Mother		
Maternal Grandparents		
1		
2		
Paternal Grandparents		
1		
2		
Brother(s) and Sister(s)		
1		
2		
3		
4		
5		

Family Medical: Have any family members had ___?			
ADD/ADHD		Genetic Disorder	
Allergies		Heart Problems	
Anemia		High Cholesterol	
Asthma		High Blood Pressure	
Birth Defects		Learning Disability	
Blood Disorder		Mental Illness	
Cancer		Mental Retardation	
Curved Spine		Migraines	
Deafness		Obesity	
Depression		Seizure Disorder	
Developmental Delay		Sudden Infant Death	
Diabetes		Thyroid Disease	
Drug/alcohol abuse		Other:	
Eczema			

Safety		
Is there a smoke alarm in the home?	Y	N
Carbon monoxide alarm in the home?	Y	N
Guns in the household?	Y	N
Secondhand tobacco smoke?	Y	N
Prescription pain meds in the home?	Y	N
Marijuana or other drug use in the home?	Y	N

Meds		
Any daily over-the-counter medications?	Y	N
If Yes, which ones?		
1		
2		
3		
4		

FORM CONTINUES ON THE OTHER SIDE

PEDIATRIC HISTORY QUESTIONNAIRE

For children up to 3 years old:

Delivery/Newborn Period:		Birth History: During pregnancy, did mother	
Delivery Type (circle): Vaginal	C-Section	Smoke?	○ Y ○ N
Birth Weight:		Drink alcohol?	○ Y ○ N
Problems in Newborn Period:		Use Drugs/Medications?	○ Y ○ N
		Experience illness?	○ Y ○ N

For children to 3 to 9 years old:

Where does your child go to school?	What grade?		
Has your child repeated or been held back a grade?		○ Y	○ N
Has your child attended a special class?		○ Y	○ N
Does your child have behavior problems at school?		○ Y	○ N
Has your child had any bullying problems?		○ Y	○ N
How much screen time (video, TV, computer, phone) during a typical day?		_____ hours per day	

For children 10 to 12 years old:

Where does your child go to school?	What grade?		
Has your child repeated or been held back a grade?		○ Y	○ N
Has your child attended a special class?		○ Y	○ N
Does your child have behavior problems in school?		○ Y	○ N
Has your child had any bullying problems?		○ Y	○ N
Any academic problems?		○ Y	○ N
How much screen time (video, TV, computer, phone) during a typical day?		_____ hours per day	
Any concerns about body image?		○ Y	○ N
Please explain any Yes answers:			

For children 13 to 18 years old:

Where does your child go to school?	What grade?		
Does your child have behavior problems in school?		○ Y	○ N
Has your child had any bullying problems?		○ Y	○ N
Any academic problems?		○ Y	○ N
How much screen time (video, TV, computer, phone) during a typical day?		_____ hours per day	
Any concerns about body image?		○ Y	○ N
Concerns about sexuality?		○ Y	○ N
Do you use alcohol?		○ Y	○ N
Do you use tobacco?		○ Y	○ N
Do you use caffeine, coffee, tea, soda, power drinks?		○ Y	○ N
Do you use “recreational drugs”?		○ Y	○ N
Are you sexually active?		○ Y	○ N
If yes, with whom?	○ Males	○ Females	○ Both
Do you see a dentist? Who?		○ Y	○ N
Any concerns for depression or anxiety?		○ Y	○ N
Have you ever been abused?	○ physically	○ mentally	○ sexually
Are you satisfied with your weight?		○ Y	○ N
What do you do for exercise?			
How often do you exercise?			
Do you always wear a seat belt?		○ Y	○ N
If you ride a bike or motorcycle, do you always wear a helmet?		○ Y	○ N
Are guns kept in your home?		○ Y	○ N
If yes, is the household aware of gun safety?		○ Y	○ N

Physician: _____ Date: _____

503.659.4988 **NWPC.com**

Authorization to Release Medical Information

Patient Name _____ Former Name (if any) _____

Current Address _____ D.O.B _____
Street, City, State, Zip

Home Phone _____ Work Phone _____ S.S.# _____

I Authorize Information Released FROM: (Please Print)	**Please Send My Records TO:** (Please Print)
Name _____	Name _____
Address _____	Address _____
City, State, Zip _____	City, State, Zip _____

Purpose of Release

- ☐ Dissatisfied with practitioner
- ☐ Dissatisfied with staff
- ☐ Transfer of care
- ☐ Moving
- ☐ Personal use
- ☐ Insurance change
- ☐ Referral/Consultation
- ☐ Legal
- ☐ Other _____

Permission to Fax Information: I consent to the faxing of my medical records. All faxed documents contain a confidentiality statement, however, I understand confidentiality at the receiving end cannot be guaranteed. ☐ YES ☐ NO

I would like records sent via: ☐ CD (Adobe 8 or higher) ☐ Paper (***If not checked, CD is the default method.)***

Type of Information To Be Released

☐ General Medical Records (Consists of the last two years of treatment)

☐ **Specific Information Only**: please specify _____

Protected or Sensitive Information: I understand that certain information cannot be released without specific authorization as required by State/Federal Law. **BY INITIALING** I authorize the release of the following protected or sensitive information:

_____ Initial Drug/Alcohol Diagnosis/Treatment/Referral Information

_____ Initial Mental Health/Treatment

_____ Initial Genetic Testing Information

_____ Initial HIV/AIDS Information

You will not be denied treatment if you refuse to sign the authorization form unless treatment to be provided is considered research related treatment.

You have the right to revoke this authorization at any time, provided that you do so in writing to Northwest Primary Care Group. If you revoke your authorization, we will no longer use or disclose information about you for the reasons covered by your written authorization, but we cannot take back any uses or disclosures already made with your permission.

This authorization will expire in 180 days from the date of signing, or unless otherwise specified _____

I have reviewed and I understand this authorization. I also understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

BY: _____ DATE: _____
Patient or Patient Representative

Description of Representative's Authority: _____

☐ **Dwyer Clinic**
Internal Medicine
10024 SE 32nd Ave • Milwaukie, OR 97222
PH: 503.659.4988 • FX: 503.654.5666

☐ **Milwaukie Clinic**
Family Medicine
3033 SE Monroe St • Milwaukie, OR 97222
PH: 503.659.4988 • FX: 503.659.4730

☐ **Talbert Clinic**
Family Medicine
12360 SE Sunnyside Rd • Clackamas, OR 97015
PH: 503.659.4988 • FX: 503.698.4018

☐ **Oregon City Clinic**
Family Medicine
1508 Division St • Building II, Suite 25
Oregon City, OR 97045
PH: 503.659.4988 • FX: 503.353.1234

☐ **Sellwood Clinic**
Family Medicine
6327 SE Milwaukie Ave • Portland, OR 97202
PH: 503.659.4988 • FX: 503.353.1297

☐ **Medical Records**
12300 SE Mallard Way, Ste 160
Milwaukie, OR 97222
PH: 503.659.4988 • FX: 503.353.1293

Instructions for completing NWPC Record Release Form:

(Important: any missing or inaccurate entries may delay or void your request)

- Photo ID may be required for patient/guardian verification
- Be sure to write legibly, to include:
    - Birthdate
    - Previous name (if any)
    - Where would you like the records sent (include address or fax number)
    - Why the records are being sent (purpose of release)
    - Type of information to be released (standard for “all records” is last two years of treatment unless specifically requested otherwise).
    - Patient/guardian signature and date
- If you want the information to be faxed, please mark on the form, “Permission to Fax”. Please note that we will not fax any records that are more than 50 pages.
- Please allow 30 days for records to be sent as per Oregon State Law.

Who can receive copies of medical records:

Adult patients - Copies of their own medical records

Parent or Legal Guardian - Copies of their minor child’s medical records

Legal Power of Attorney - Copies of the medical records of the person named in the power of attorney (for example; wife, husband or partner, disabled adult)

Personal Health Information (PHI) Consent Form

Your privacy is our most important goal. Federal law requires that your information may not be shared with anyone, unless law allows it or permission has been given.

Please note: Anyone listed below as having permission to have access to your Protected Health Information, (whether on paper, electronic, or verbal) will have access that may include specially protected records (i.e. HIV results) ORS 333-022-0210.

I,_____, authorize the following person(s)to discuss, receive written documents and/or have access to My NWPC Chart with all my personal health information (PHI), which consists of Billing/Insurance, Appointments, and all Health Information and Treatments.
Check here if you are choosing, **none:** ☐

1) _____ Relationship: _____ Phone:_____

2) _____ Relationship: _____ Phone:_____

3) _____ Relationship: _____ Phone:_____

4) _____ Relationship: _____ Phone:_____

NWPC normally will not leave detailed voice mail messages due to HIPAA concerns, unless:

O I also authorize NWPC to leave a detailed message on the phone number(s) listed on my account. _____

Patient Signature: _____ Date: _____

My NWPC Chart Email Address:

****If at any time you wish to rescind your consent, you must update this consent form at one of our clinics.****