

NAME:	DOB: <i>mm/dd/yyyy</i>	DATE:
Mother's name:	Father's name:	Other parent's name:
Who does your child live with?		

HEALTH ASSESSMENT
What is most important to you about the medical care of your child? <i>(e.g. communication, prevention, wellness planning)</i>
What specific concerns about your child would you like to address with their new clinician?

MEDICATIONS & ALLERGIES				
Please list all your child's current medications <i>(including vitamins & supplements)</i> .				
Item	Dose	Frequency	Taken for	Prescribed by
1.				
2.				
3.				
Allergies to medications and other items:				
1.				Reaction:
2.				Reaction:
Preferred pharmacy:			Phone:	Fax:
Address:				

SOCIAL HISTORY & LIFESTYLE		
Daycare/Nanny? <input type="radio"/> Yes <input type="radio"/> No	School:	Grade:
Any problems at home/school/daycare <i>(i.e. learning, behavioral etc.)?</i>		
Who lives at home with your child?		
Are there any pets in the home? <input type="radio"/> Yes <input type="radio"/> No If yes, type:		
Diet <i>(infants)</i> : <input type="radio"/> Breastfeeding <input type="radio"/> Formula <input type="radio"/> Solid foods		
Diet <i>(children or adolescents, please describe)</i> :		
Exercise or Activities		
Type:	No. of days per week:	
Type:	No. of days per week:	
Type:	No. of days per week:	
Does anyone smoke in the home? <input type="radio"/> Yes <input type="radio"/> No		
If your child is less than 4'9", does he/she use a car seat (booster seat)? <input type="radio"/> Yes <input type="radio"/> No		
If your child is under age 13, does he/she ride in the back seat of the car? <input type="radio"/> Yes <input type="radio"/> No		
Do you feel safe in your neighborhood? <input type="radio"/> Yes <input type="radio"/> No		
Are there guns in your home? <input type="radio"/> Yes <input type="radio"/> No	If yes, are they unloaded and locked away? <input type="radio"/> Yes <input type="radio"/> No	
Is there any history of abuse in your child's home or life <i>(physical, sexual, emotional, neglect)?</i> <input type="radio"/> Yes <input type="radio"/> No		

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NAME:	DOB:
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HEALTH MAINTENANCE & PREVENTION
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When was the last time your child:	
Had a well-child exam?	Visited the dentist?
Female Health	
Has your child started her period? <input type="radio"/> Yes (<i>Age</i>) <input type="radio"/> No	
Has your child had a PAP smear? <input type="radio"/> Yes <input type="radio"/> No	
If yes, when? <i>mm/yyyy</i>	Result: <input type="radio"/> Normal <input type="radio"/> Abnormal
Immunizations	
Are your child's immunizations current? <input type="radio"/> Yes <input type="radio"/> No	

PERSONAL MEDICAL HISTORY

Pregnancy complications:	Delivery complications:
Delivery method: <input type="radio"/> Vaginal <input type="radio"/> C-section	Birth weight:
Multiple births (<i>twins</i>): <input type="radio"/> Yes <input type="radio"/> No	
Has your child ever had any problems with the following: (<i>If yes, please explain.</i>)	
<input type="checkbox"/> Alcohol or substance abuse:	<input type="checkbox"/> Lungs:
<input type="checkbox"/> Cancer:	<input type="checkbox"/> Metabolism (<i>diabetes, thyroid etc.</i>):
<input type="checkbox"/> Blood:	<input type="checkbox"/> Muscle, joint, bones:
<input type="checkbox"/> Digestion:	<input type="checkbox"/> Nerves and brain:
<input type="checkbox"/> Ear, nose, throat, eyes:	<input type="checkbox"/> Skin and hair:
<input type="checkbox"/> ER Visits: Type: Date:	<input type="checkbox"/> Sleep:
<input type="checkbox"/> Heart or blood vessels:	<input type="checkbox"/> Social, mental or emotional health:
<input type="checkbox"/> Hospitalizations: Type: Date:	<input type="checkbox"/> Surgeries: Type: Date:
<input type="checkbox"/> Infectious diseases:	<input type="checkbox"/> Female health (<i>menstrual problems, etc.</i>):
<input type="checkbox"/> Kidneys or bladder:	<input type="checkbox"/> Male health (<i>testicular lump/pain</i>):
<input type="checkbox"/> Learning disabilities:	<input type="checkbox"/> Other:

FAMILY MEDICAL HISTORY

Please indicate any family members who have had the following:		
<input type="checkbox"/> Alcohol abuse:	<input type="checkbox"/> Bleeding disorders:	<input type="checkbox"/> Deafness:
<input type="checkbox"/> Arthritis:	<input type="checkbox"/> Breast cancer:	<input type="checkbox"/> Dementia:
<input type="checkbox"/> Asthma:	<input type="checkbox"/> Cancer of an unknown type:	<input type="checkbox"/> Depression:
<input type="checkbox"/> Autism:	<input type="checkbox"/> Colon cancer:	<input type="checkbox"/> Diabetes:
<input type="checkbox"/> Bipolar disorder:	<input type="checkbox"/> Cystic fibrosis:	<input type="checkbox"/> Glaucoma:
<input type="checkbox"/> Heart attack:	<input type="checkbox"/> Lymphoma/Leukemia:	<input type="checkbox"/> Schizophrenia:
<input type="checkbox"/> Heart disease:	<input type="checkbox"/> Osteoporosis:	<input type="checkbox"/> Sickle cell anemia:
<input type="checkbox"/> High blood pressure:	<input type="checkbox"/> Ovarian cancer:	<input type="checkbox"/> Skin cancer:
<input type="checkbox"/> High blood cholesterol:	<input type="checkbox"/> Obesity:	<input type="checkbox"/> Stroke:
<input type="checkbox"/> HIV:	<input type="checkbox"/> Parkinson's disease:	<input type="checkbox"/> Substance abuse:
<input type="checkbox"/> Inherited anemias (<i>i.e. thalassemia</i>):	<input type="checkbox"/> Prostate cancer:	<input type="checkbox"/> Thyroid:
<input type="checkbox"/> Inflammatory bowel disease (<i>e.g. Crohn's disease</i>):	<input type="checkbox"/> Other cancer:	
<input type="checkbox"/> Any other condition that two or more relatives have?		

Please attach your child's immunization record to this form.



Health History Survey *Optional*

This section describes the care your child received prior to joining Qliance. Please score the following questions using a scale of 0-10, with 0 being strongly disagree and 10 being strongly agree. These questions are *optional* and the answers you provide are confidential.

Score (0-10)

My child has been able to get care from his/her primary care clinician when and how they need it.	
My child has had a personal health care provider (doctor, nurse practitioner etc.) who knows them as a person.	
The bulk of my child's health care needs have been met by their primary care provider's office.	
My child's primary care clinician has coordinated their care throughout the health care system.	
When my child has visited their primary care provider's office, it has been organized and efficient.	

PATIENT SELF HEALTH ASSESSMENT

How do you rate your child's health? <input type="radio"/> Poor <input type="radio"/> Fair <input type="radio"/> Good <input type="radio"/> Very Good <input type="radio"/> Excellent	
During the past 4 weeks, how much trouble has your child had engaging in their usual activities because of their physical or emotional health? <input type="radio"/> No difficulty <input type="radio"/> A bit of difficulty <input type="radio"/> Some difficulty <input type="radio"/> Much difficulty <input type="radio"/> Could not engage in usual activities	
During the past 4 weeks, how much school or activities has your child missed due to physical or emotional problems? <input type="radio"/> Not at all <input type="radio"/> 10-20% <input type="radio"/> 21-30% <input type="radio"/> More than 30%	
During the past 4 weeks, has your child's physical or emotional health limited their social activities?	<input type="radio"/> Yes <input type="radio"/> No
In the past 3 months has your child had any injury or illness that has kept them in bed for all or most of the day?	<input type="radio"/> Yes <input type="radio"/> No
In the past year, has your child gone to the ER for care?	<input type="radio"/> Yes <input type="radio"/> No
In the past year, has your child stayed in the hospital overnight or longer?	<input type="radio"/> Yes <input type="radio"/> No