Capital Internal Medicine Associates, P.C.

*A New Beginning OB/GYN *CIMA Breast Center
*CIMA Main Office Haslett Primary Care *Mount Hope Clinic
*Williamston Primary Care

PLEASE COMPLETE THIS PEDIATRIC QUESTIONNAIRE

Patient Name: _____ Birthdate: __/___/____

Parent Name Completing Information: _____

PARENT INFORMATION

Single:____ Married: ____ Divorced:____ Separated:____ Widowed:____ Life Partner:____

Did mother smoke during pregnancy? Yes No If so, how many packs per day? _____

Did mother consume alcohol during pregnancy? Yes No How many per day? _____ Week? _____

Did mother consume caffeine? Yes No If so, how much per day? _____

Did mother take any medication during pregnancy? Yes No If so, what? _____

Does anyone smoke in the home? Yes No How many packs per day? _____

Does anyone in the home use any recreational drugs? Yes No If so, what? _____
(Marijuana, Cocaine, LSD, Speed, Crack, Heroine, Steroids, Medications not prescribed to you)

BIRTH HISTORY

☐ Vaginal Birth ☐ Caesarian If caesarian, why? _____

Length of Pregnancy (# of weeks) _____ If Premature, how early? _____

Birth Weight: _____ Birth Length: _____

☐ Home ☐ Hospital ☐ Birthing Center

Name of Facility: _____

City: _____ State: _____ Zip Code: _____

☐ Breast Fed, How Long? _____ ☐ Formula, Brand/Type? _____

☐ Other: _____

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PC Employee Benefits Plan complies with applicable Federal civil rights laws
and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Spanish	ATENCIÓN:	si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-517-374-7600.
Arabic	ملحوظة:	بـرقم اتصـل .بالمجـان لـك تتوافـر اللغويـة المسـاعدة خدمات فـإن ،اللغـة اذكر تتحـدث كنـت إذا 1-517-374-7600

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IMMUNIZATIONS

Were Immunization(s) given in Michigan? Yes No

If the child has received immunizations, but not in Michigan, please provide when they received them and in what state they were administered: _____

If there is another name the child may have used when receiving the immunizations, please provide the name(s): _____

PATIENT HEALTH INFORMATION

PLEASE CIRCLE IF YOUR CHILD HAS BEEN DIAGNOSED WITH:

ADD/ADHD	Abdominal Pain	Allergies	Anxiety
Asthma	Birth Complications	Bone Fracture	Cancer
Chronic Ear Infections	Concussion/Head Injury	Constipation	Depression
Eczema	Headaches	Hearing Problems	Joint Pain
Piercing(s)	Poor Appetite	Rapid Pulse	Scoliosis
Seizures	Shortness of Breath	Speech Development Delay	Tattoo(s)
Vision Problems	Weight Gain	Weight Loss	

Other: _____

Any surgical implant(s)? Yes No If yes, where? _____

Please list any surgeries: _____

RECENT TESTING ACTIVITY

Please Indicate the Most Recent Date These Test Were Performed

Lead Levels	Date last tested: _____
Dental	Date last exam: _____
Hearing	Date last tested: _____
Vision	Date last exam: _____

LIST YOUR PREVIOUS PRIMARY CARE DOCTOR and ANY SPECIALISTS THAT YOU SEE or HAVE SEEN IN THE PAST:

_____

_____

_____

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Family History: (Please check all boxes that apply in table below)

Please tell us about medical problems in your blood relatives. This can help us take better care of you. Fill out the chart below by checking all the appropriate boxes that apply to each relative.

	AGE (years old)	DECEASED (Y/N)	DIABETES	HYPERTENSION	HEART DISEASE/CHF/MI	STROKE	ASTHMA	CANCER	UNKNOWN	ALLERGIES	MENTAL ILLNESS	DEPRESSION	OSTEOPOROSIS	COPD	HYPERLIPIDEMIA	OTHER:
MOTHER		Y/N														
FATHER		Y/N														
MOTHERS MOTHER		Y/N														
MOTHERS FATHER		Y/N														
FATHERS MOTHER		Y/N														
FATHERS FATHER		Y/N														
BROTHERS		Y/N														
SISTERS		Y/N														
CHILDREN		Y/N														

CURRENT MEDICATIONS

Please list medication that you are currently taking.

PLEASE LIST MEDICATIONS YOU ARE USING:

MEDICATION TAKING	DOSAGE	REASON FOR USING

PLEASE LIST ANY ALLERGIES AND YOUR REACTION TO THEM

ALLERGY/MEDICATION	REACTION

Thank you for taking the time to fill out this form!

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Patient Preferences for Communication of Protected Health Information

***** *Please note the named individuals below may not access, request, or receive copies of your medical records without an Authorization for Release of Medical Records signed by you.* ****

Printed Name: _____DOB_____ Acct #_____

Primary Care Provider: _____

Emergency Contact: Name:_____ Phone Number: _____

DPOA/Guardian (if applicable): _____

People who may receive information: **Info allowed (please ✓)**

Name	Relationship	Phone Number	Any Info	Return Call Only

1. May we leave a message on your voicemail with medical advice or test results? Yes ☐ No ☐
2. Choose **ONE** preference for receiving appointment reminders?
   Text ☐ Voicemail ☐
3. If you wish to use an address other than your home address for written communication, please provide alternate address_____
4. I understand that this form remains in effect until renewed or revoked. I acknowledge it is my responsibility to update this form if there are any changes Initial_____

Policies and Limitations on Alternate Means of Communication:

- We are required to accommodate "reasonable" requests for communicating with you by alternate means. We may deny the request if we determine that it is unreasonable.
- You agree that the security and confidentiality of the confidential information sent via alternate method is your responsibility alone, and neither the provider nor the practice are responsible for any inadvertent disclosures that may occur as a result of fulfilling the request.

Patient Signature: _____ Date: _____

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3955 Patient Care Dr. Suite A
Lansing, MI 48911

Phone: (517) 374-7600 Fax: (855) 505-8064

Authorization for Use or Disclosure of Information

*Patient Name: _____*Maiden/Other Name _____

*D.O.B._____/_____/_____ *Phone Number (_____) _____

*Patient Address: _____
Street City State Zip

I authorize_____
Healthcare Facility/Physician

To release any and all information contained in the record which may include information regarding: **Drug and/or alcohol treatment, psychological records, HIV/AIDS and other Sexually Transmitted Disease.**

Name to whom information may be released: _____
Physician/Facility/Self

***Please send most recent:**

☐ Entire Medical Record ☐ Discharge Summary ☐ Colonoscopy ☐ Operative Report
(5 Years of Records provided, unless otherwise specified)

☐ Radiology/Diagnostic Reports ☐ Laboratory Reports ☐ Pathology Reports ☐ Progress Notes

☐ Radiology/Diagnostic Imaging ☐ Medications ☐ Immunizations ☐ Billing Records

☐ Emergency Room Records ☐ Other (Specify): _____

***Information to Be Released (From Date: _____ To Date: _____)**

Here at CIMA we are constantly trying to improve our quality of care, if you are leaving the practice please give a brief description as to why: (optional) _____

_____

This authorization expires (Date): _____ (if no date is given this release will expire one year from date of patient's signature)

I understand that, as set forth in the practice's Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending written notification.

I understand that a revocation is not effective to the extent that the practice has relied on the use or disclosure of the protected health information.

_____ _____/_____/_____
Signature of Patient or Personal Representative Date

_____
Printed Name of Patient or Personal Representative (if necessary)

_____
Person Authorized to Pick-up on Patient's Behalf

This form for Authorization for Use or Disclosure of Information is designed to comply with Title 42 of Federal Regulations, Part 2 (HIPAA).

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Arabic	ملحوظة:	إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-517-374-7600