WENTWORTH HEALTH PARTNERS

YOUTH HEALTH QUESTIONNAIRE

Outside Note Other

Patient Identification Area

Patient Name: _____ **DOB:** _____ **AGE:** _____ **Sex:** ❑ **M** ❑ **F**

CURRENT MEDICATIONS (may bring own list to visit if you prefer)

Name of Medication	Strength of Medication	Dosing Instructions

* Note − this information may be taken directly from the pharmacy label on prescription products

ALLERGIES

❑ No Known Allergies ❑ Medication Allergies ❑ Environmental/Seasonal Allergies ❑ Latex Allergy

Please specify Allergen AND Reaction below:

_____

_____

_____

_____

PAST MEDICAL HISTORY

Please list medical history for this patient and if possible indicate the age at diagnosis for each condition.

❑ Allergies ❑ Asthma ❑ ADD / ADHD ❑ Congenital Defect ❑ Mood/Behavior Disorder

❑ Other _____

_____

_____

_____

PAST SURGICAL HISTORY

Please list surgical history and hospitalizations for this patient and if possible list the age or year when surgery (or hospitalization) was performed.

Date of Surgery or Hospitalization	Age or Year	Surgery (Operation) or Reason for Hospitalization

We would like to personally thank you for taking the time to complete this form. Doing so provides us with the information necessary to make the most out of each and every healthcare visit together.

WENTWORTH HEALTH PARTNERS

Patient Identification Area

YOUTH HEALTH QUESTIONNAIRE

Patient Name: _____ **DOB:** _____

FAMILY HISTORY (Check all that apply)

❑ Allergies ❑ Anemia ❑ Asthma ❑ Cancer (specify)_____
❑ Diabetes ❑ Epilepsy/Seizure Disorder ❑ Heart Disease
❑ High Blood Pressure ❑ High Cholesterol ❑ Mental Illness
❑ Other (please list) − _____

SOCIAL HISTORY

Family Information

Mother's Name: _____ Mother's Occupation: _____

Father's Name: _____ Father's Occupation: _____

Siblings: ❑ Yes ❑ No Sibling Names and Ages _____

Guardian Name and Relationship (if applicable): _____

If parents live separately, where is the child's primary residence? _____

Who lives at home? _____

Are there pets in the home? ❑ Yes ❑ No If yes, specify type and name _____

Does anyone in the home smoke? ❑ Yes ❑ No

Child Care and Education

Does this child attend child care? ❑ Yes ❑ No

If yes, what is the name of the child care center? _____ If yes, how many hours per week?_____

Does this child attend school? ❑ Yes ❑ No

If yes, what is the name of the school? _____ If yes, what grade? _____

Do you have concerns about your child's adjustment or performance in school? ❑ Yes ❑ No

If yes, please explain: _____

_____

Learning Needs

Is your primary language English? ❑ Yes ❑ No If no, please note primary language: _____

How would you like health information about your child/youth presented?

❑ 1:1 Conversations with health care provider ❑ Reading Materials ❑ Classroom

Who makes up your household? (check all that apply):

❑ Single Parent ❑ Two parent household ❑ Siblings ❑ Others, not family

Interests / Hobbies / Recreational Activities: _____

_____

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Patient Name: _____ **DOB:** _____

Tobacco Exposure *(check all that apply)*

❑ Patient is a Smoker ❑ Smokers in Home ❑ Smoke outside only

Activity (check all that apply)

❑ Exercise/Sports (Hours per day) ❑ TV / Computer Games (Hours per day)

❑ Internet (Hours per day) ❑ Text Messaging (Hours per day)

Sleep (check all that apply)

❑ Takes Naps ❑ Sleeps with Parents ❑ Sleeps through the night ❑ Minimum 8 hours nightly ❑ Nightmare/sleep problems

Safety (check all that apply)

❑ Uses bike helmet ❑ Car Seat Rear Facing ❑ Car Seat Front Facing ❑ Booster ❑ Seat Belt ❑ Carbon Monoxide Detector

❑ Smoke Detectors ❑ Radon Detectors ❑ Fire Arms in Home ❑ Pool/Spa ❑ Pet / Animals Type & Number _____

CONCERNS

Please list any concerns you have regarding the health of this child in the space provided.

_____

_____

_____

_____

_____

_____

Name and Relationship of Person Completing Form (print): _____

Signature: _____ **Date:** _____

We would like to personally thank you for taking the time to complete this form. Doing so provides us with the information necessary to make the most out of each and every healthcare visit together.

PRINT SAVE AS RESET

PARTNERS HEALTHCARE

WENTWORTH-DOUGLASS HOSPITAL
A Mass General Community Hospital

Mail or Fax To:
Release of Information
121 Inner Belt Road, Room 240
Somerville, MA 02143−4453
Phone: 617−726−2361
Fax: 844−918-0781

AUTHORIZATION FOR RELEASE OF PROTECTED OR PRIVILEGED HEALTH INFORMATION

Please print all information clearly in order to process your request in a timely manner.

A. PATIENT INFORMATION

PATIENT NAME: _____ **PATIENT DATE OF BIRTH:** _____

PATIENT MEDICAL RECORD #: _____

PATIENT ADDRESS: STREET: _____ **APT. #:** _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

TELEPHONE CONTACT #: DAY: ( ) _____ **EVENING: ( )** _____

B. PERMISSION TO SHARE: I give my permission to share my protected health information. Enter where you would like information sent from, and to whom you would like the information sent.

FROM: (e.g. hospital, clinic, or provider name):

Name: _____

Address: _____

_____

Telephone Number: _____

PURPOSE: (check the appropriate box):

- ❑ Medical Care
- ❑ Insurance*
- ❑ Legal Matter*
- ❑ Personal*
- ❑ School
- ❑ Other (please specify)* _____

* Copying fees may apply

TO: (e.g. to whom you would like the information sent):

❑ Check here if the records are to be mailed to the patient at the above address (section A), otherwise complete the information below to indicate where you would like the information sent:

Name: _____

Address: _____

_____

Telephone Number: _____

SEND BY:

- ❑ Partners Patient Gateway (if available)
- ❑ Secure Email (provide email address below)
  Patient Email Address: _____
- ❑ Paper Copy via Mail
- ❑ Fax (provide fax number): _____

C. INFORMATION TO BE RELEASED (Please check all that apply, and specify dates):

- ❑ Medical Record Abstract/dates: _____
  (e.g. History & Physical, Operative Report, Consults, Test Reports, Discharge Summary)
- ❑ Clinic Visit Notes/dates: _____
- ❑ Discharge Summary/dates: _____
- ❑ Lab Reports/dates: _____
- ❑ Operative Reports/dates: _____
- ❑ Pathology Reports/dates: _____
- ❑ Radiation Reports/dates: _____
- ❑ Radiology Reports/dates: _____
- ❑ Photographs/dates (costs may apply): _____
- ❑ Billing Records/dates: _____
- ❑ Other *(please specify below and include dates):* _____

_____

_____

_____

_____

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PARTNERS HEALTHCARE

WENTWORTH-DOUGLASS HOSPITAL
A Mass General Community Hospital

AUTHORIZATION FOR RELEASE OF PROTECTED OR PRIVILEGED HEALTH INFORMATION

D. Please check YES to indicate if you give permission to release the following information if present in your record:

❑ Yes **HIV test results** (PATIENT AUTHORIZATION REQUIRED FOR EACH RELEASE REQUEST.)
SPECIFY DATES:_____

❑ Yes **Genetic Screening test results (SPECIFY TYPE OF TEST):** _____

❑ Yes **Alcohol and Drug Abuse Records** Protected by Federal Confidentiality Rules 42 CFR Part 2 (FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED BY WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2.) This consent may be revoked upon oral or written request.

❑ Yes **Other(s):** Please List: _____

❑ Yes Details of Mental Health Diagnosis and/or Treatment provided by a Psychiatrist, Psychologist, Mental Health Clinical Nurse Specialist, or Licensed Mental Health Clinician (LMHC) (I understand that my permission may not be required to release my mental health records for payment purposes)

❑ Yes Confidential Communications with a Licensed Social Worker

❑ Yes Details of Domestic Violence Victims' Counseling

❑ Yes Details of Sexual Assault Counseling

E. I understand and agree that:

- Partners HealthCare System (PHS) cannot control how the recipient uses or shares the information, and that laws protecting its confidentiality at PHS may or may not protect this information once it has been released to the recipient
- This authorization is voluntary
- My treatment, payment, health plan enrollment, or eligibility for benefits will not be affected if I do not sign this form
- I may cancel this authorization at any time by submitting a written request to the Department or Office where I originally submitted it, except:
  - ❍ if PHS has already relied upon it (for example, once information is released, it will not be retrieved)
  - ❍ if I signed this authorization as a condition of obtaining insurance, other laws may provide the insurer with a right to contest a claim under the policy or the policy itself
- This authorization will automatically expire **6 months from the date signed** unless otherwise specified:
- I understand that if Partners maintains any of my records from outside providers, these will not be released unless I specifically ask for them under "Other" in section C. Please include entity name, provider, and specific dates if known.
- My questions about this authorization form have been answered

➢ **Patient's Signature:** _____ ➢ **Date:** _____

➢ **Print Name:** _____

When patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required.

➢ **Signature of Legal Representative:** _____ **Date:** _____

Print Name: _____ **Relationship of representative to patient:** _____

For Internal Use Only

Information Released/Reviewed By: _____ Date: _____

Clinic/Office: _____

Pick−up Identification:

❑ License ❑ State ID ❑ Passport ❑ Other Photo ID _____

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