

Harmony Health Services

Child Medical History Form

Name: _____ Date of Birth: _____

Mother's Name: _____ Father's Name: _____

Brothers/Sisters Name(s): _____

Does the child attend daycare? Yes No Are there pets in the home? Yes No

Does either parent work: Yes No If yes, where: _____

Does either parent smoke: Yes No, If yes, who? _____

Child's weight at birth: _____ Child's length at birth: _____

Current Health Habits:

Bowel Movements/Stools:

_____ Applesauce	_____ Brown/Green	_____ Curdly	_____ Greenish-Black
_____ Hard	_____ Light Brown	_____ Loose	_____ Mushy
_____ Seedy Yellow	_____ Mustard-Like	_____ Soft	_____ Watery

Feedings:

_____ Breast _____ Bottle

Time child nurses on each breast: _____ 10 minus _____ 15mins _____ 20mins

Formula:

_____ Enfamil/Similac	_____ Hypo-allergenic Formula	_____ Isomil/Prosobee
_____ Lactose Free Formula	_____ Neocare	_____ Other _____

Ounces of formula per feeding: _____ 2oz _____ 3oz _____ 4oz _____ 5oz _____ 6oz _____ 7oz
_____ 8oz _____ Other _____

How long between each feeding:

_____ 2hours _____ 3hours _____ 4hours _____ 5hours
_____ 6hours _____ on demand _____ has to awakened for feeding.

How often does the baby feed during the night: _____ 2times _____ 3times _____ more than 3x's

Urination: _____ Less than 5 wet diapers daily _____ 5-6 per day _____ more than 6
_____ off smelling urine _____ strong smelling urine

Do you notice any hearing problems: Yes No Do you notice any vision problems? Yes No

Concerns: _____

Signature: _____

Date _____

Harmony Health Services

Consent for Communication Health Information to Personal Representatives

Name: _____

Address: _____

City, State, Zip Code

Telephone Number: _____

Date: _____

I, give my written consent for Harmony Health Services to share information regarding my protected Health Information (HIPAA) and care to the following listed person(s). I understand that these person(s) may be treated as personal representative(s) of myself.

Personal Representative(s) that you may share my health information with:

Name	Relationship	Telephone Number
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_____	_____	_____
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_____	_____	_____
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You may leave a message (please check all that apply)

_____ at home

_____ at work

_____ answering machine/voice mail

Verification Data: _____

Mother's Maiden Name

City of Place of Birth

Patient's Signature

Date

Witness

PHARMACY VERIFICATION

NAME: _____

PHARMACY: _____

DATE: _____

The pharmacy that you have chosen above will be the pharmacy that all of your medications will be sent to.

If you decide to use another pharmacy, you will need to come in and sign a new form. No medications will be sent to a pharmacy other than the one you have on file with us.

Our policy is that all prescription refills require a 24 hour notice.

Please check with your pharmacy 24 hours after you have contacted our office for the refill. If the pharmacy does not have the prescription, please have the pharmacy call the office.

We only need one call for your prescription refill. We ask that you do not call our office multiple times.

Thank you.