PEDIATRIC Medical History Disclosure (MHD)—Teladoc

To be completed for all members under 7 years of age. A standard MHD should be completed for members 7 years of age and older.

***CHILD'S LEGAL NAME:** ______________________ ***BIRTHDATE:** ____________ ***GENDER:** M / F
***COMPANY NAME:** ______________________
***CHILD'S FATHER:** ______________________ ***CHILD'S MOTHER:** ______________________
***MAILING STREET ADDRESS:** ______________________
***CITY/ST/ZIP:** ______________________ **Ethnicity:** ____________
CHILD'S BROTHERS/SISTERS (and date of birth)**:** ______________________

***CURRENT DEVELOPMENT OF CHILD** (approximate)**: *Height** ____ ***Weight:** ____ **Child care outside of home:** ❑ Yes ❑ No
Primary Care Physician: ______________ **Primary Care Physician's contact number:** ______________

DEVELOPMENT HISTORY: At what approximate age did your child: Sit up _____ Crawl _____ Walk _____ First Word _____
Doctor Who Delivered: ______________ **Facility/Location:** ______________
Birth Weight: ____________ **Birth Length:** ____________ **Birth Head Circumference:** ____________
Delivery Type: ____________ **Vacuum/Forceps Assisted:** ____________ **Full/Preterm** (Total Weeks): ____________
Was Child: **Breast fed?** ❑ Yes ❑ No If yes, how long?__________ **Bottle fed?** ❑ Yes ❑ No If yes, how long?__________

Complete the following questions relative to the child's medical history. The MHD is confidential and only reviewed by a physician.
All questions marked with an asterisk (*) must be answered prior to requesting a consult.

Pregnancy History

Smoking	❑ Yes ❑ No	Medication(s)	❑ Yes ❑ No	Drugs/Alcohol	❑ Yes ❑ No
Bleeding	❑ Yes ❑ No	High Blood Pressure	❑ Yes ❑ No	Premature Labor	❑ Yes ❑ No
Infections	❑ Yes ❑ No	Toxemia	❑ Yes ❑ No	Preeclampsia	❑ Yes ❑ No
Other (explain)					

Problems during his/her newborn period

Jaundice	❑ Yes ❑ No	Breathing Problems	❑ Yes ❑ No	Infections	❑ Yes ❑ No
Colic	❑ Yes ❑ No	Feeding Problems	❑ Yes ❑ No		
Other (explain)					

***Child's Medical History:** Does the child currently, or has he/she ever had any problems in the following areas?
Mark "Yes" or "No". If condition is current, notate by checking the "Current" box.

		Current			Current			Current
Asthma	❑ Yes ❑ No	❑	Pneumonia	❑ Yes ❑ No	❑	Chronic Cough	❑ Yes ❑ No	❑
Seasonal Allergies	❑ Yes ❑ No	❑	Post-nasal Drip	❑ Yes ❑ No	❑	Frequent 'Colds'	❑ Yes ❑ No	❑
Ear Infections	❑ Yes ❑ No	❑	Ear Tubes	❑ Yes ❑ No	❑	Nose Bleeds	❑ Yes ❑ No	❑
Eye Surgery	❑ Yes ❑ No	❑	Glasses	❑ Yes ❑ No	❑	Contacts	❑ Yes ❑ No	❑
Mouth Sores	❑ Yes ❑ No	❑	Thyroid Disorder	❑ Yes ❑ No	❑	Heart Disease	❑ Yes ❑ No	❑
Heart Murmur	❑ Yes ❑ No	❑	Elevated Cholesterol	❑ Yes ❑ No	❑	Skin Problems	❑ Yes ❑ No	❑
Sleep Apnea	❑ Yes ❑ No	❑	Heart Surgery	❑ Yes ❑ No	❑	Anemia	❑ Yes ❑ No	❑
Bleeding Disorder	❑ Yes ❑ No	❑	Diabetes	❑ Yes ❑ No	❑	Hepatitis	❑ Yes ❑ No	❑
Chronic Constipation	❑ Yes ❑ No	❑	Chronic Diarrhea	❑ Yes ❑ No	❑	Stomach Pain	❑ Yes ❑ No	❑
Swollen Painful Joints	❑ Yes ❑ No	❑	Chronic Muscle Aches	❑ Yes ❑ No	❑	Bedwetting (after age 3)	❑ Yes ❑ No	❑
Headaches/Migraines	❑ Yes ❑ No	❑	Urinary Tract Infections	❑ Yes ❑ No	❑	Learning Disorder	❑ Yes ❑ No	❑
Behavioral Disorder	❑ Yes ❑ No	❑	ADD/ADHD	❑ Yes ❑ No	❑	Tonsil/Adenoid Problem	❑ Yes ❑ No	❑
Other (explain):								

***Child's Allergies** (note reaction for each)

***Medication**	**Reaction**
***Food**	

***Please List All Current Medications.** Include quantity and frequency (whether prescribed or over-the-counter): ______________
____

***Immunizations:** Please check all immunizations that are current.
❑ DTap ❑ Td ❑ HiB ❑ HBV ❑ MMR ❑ VAR ❑ HAV ❑ PCV-7 ❑ Synagis ❑ Influenza ❑ Other: __________

Tests

Test	Yes/No	Date of most recent	Test	Yes/No	Date of most recent
Chest X-ray	❑ Yes ❑ No		CBC	❑ Yes ❑ No	
Fasting Blood Sugar	❑ Yes ❑ No		Thyroid Panel	❑ Yes ❑ No	
Lipids (Cholesterol)	❑ Yes ❑ No		Hearing Test	❑ Yes ❑ No	
Chemistry Panel	❑ Yes ❑ No		Vision Test	❑ Yes ❑ No	
Urine Test	❑ Yes ❑ No		TB (PPD) Test	❑ Yes ❑ No	
Other (details):					

Family History

Question	Answer	Relationship to Child
1. Asthma	❑ Yes ❑ No	
2. Anesthetic Reaction	❑ Yes ❑ No	
3. Bleeding Disorder	❑ Yes ❑ No	
4. Cystic Fibrosis	❑ Yes ❑ No	
5. Cancer (and type)	❑ Yes ❑ No	
6. Diabetes (type I or II)	❑ Yes ❑ No	
7. Elevated Cholesterol	❑ Yes ❑ No	
8. Heart Disease	❑ Yes ❑ No	
9. Early/Unexplained Death	❑ Yes ❑ No	
10. Muscular Dystrophy	❑ Yes ❑ No	
11. Seasonal Allergies	❑ Yes ❑ No	
12. Sickle Cell Anemia	❑ Yes ❑ No	
13. Thyroid Disease	❑ Yes ❑ No	
14. Other (explain)	❑ Yes ❑ No	

Terms & Conditions: Read the following terms and conditions of your Teladoc membership and indicate that you understand and agree to the terms by signing below.

1. You are entering into a doctor/patient relationship with the doctors of TelaDoc Physicians, P.A., and you agree to pay for medical consultations at the time a medical consultation is requested, unless payment arrangements have been established through your employer, association, or other entity.
2. You agree to the entry of your medical records into the Teladoc computer database and understand that all reasonable measures have been taken to safeguard your medical information, in accordance with federal HIPAA standards, but no computer or phone system is totally secure. Teladoc recognizes your privacy and, in accordance with our Privacy Policy, will not release information to anyone without your written authorization or as required by law, or in accordance with your health insurer's privacy policy if applicable.
3. You agree to complete a medical history disclosure form that Teladoc will store electronically and make available to each Teladoc physician who performs a telephonic consultation for you.
4. You acknowledge that you already have a primary care physician and that Teladoc is not a substitute for your primary care physician.
5. You agree to designate TelaDoc Physicians, P.A. as your physician when your primary care physician is not available.
6. You acknowledge that Teladoc physicians will not prescribe any Drug Enforcement Agency controlled substances nor do they guarantee that a prescription will be written.
7. Additionally, there is no guarantee that you will be accepted as a patient.
8. If you are accepted as a patient by a Teladoc physician, you have a right to your medical records in accordance with applicable law.

I am the parent or legal guardian for the above referenced child and am authorized to consent to medical treatment for such child. I am authorized and have true and complete knowledge of this child's medical history to accurately and fully complete the medical disclosure form for the child referenced above in the event that the services of a doctor of the TelaDoc Physicians, P.A. are sought for such child.

I HAVE READ, UNDERSTAND AND HEREBY CONSENT AND AGREE TO ALL OF THE TERMS AND CONDITIONS DESCRIBED HEREIN.

REQUIRED → **Child's Legal Name:** ______________________________

Signature of Primary Member: ______________________________ **Relationship to Child:** ____________

Print Primary Name: ______________________________ **Date of Completion:** ____________

Person Completing Form: ______________________________ **Relationship to Child:** ____________

Please fax or mail this completed form to the Teladoc Customer Relations Department:

Fax (972) 661-2312 * 4100 Spring Valley, Ste 515, Dallas TX 75244