

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	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medication(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Drugs/Alcohol	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Premature Labor	<input type="checkbox"/> Yes <input type="checkbox"/> No
Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No	Toxemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Preeclampsia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other (explain) _____					

Problems during his/her newborn period

Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Breathing Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
Colic	<input type="checkbox"/> Yes <input type="checkbox"/> No	Feeding Problems	<input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Seasonal Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Post-nasal Drip	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Frequent 'Colds'	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Ear Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Ear Tubes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Nose Bleeds	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Eye Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Glasses	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Contacts	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Mouth Sores	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Thyroid Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Elevated Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Skin Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Sleep Apnea	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Heart Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Chronic Constipation	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Chronic Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Stomach Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Swollen Painful Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Chronic Muscle Aches	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Bedwetting (after age 3)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Headaches/Migraines	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Urinary Tract Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Learning Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
Behavioral Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	ADD/ADHD	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Tonsil/Adenoid Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>
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		Date of most recent		Date of most recent
Chest X-ray	<input type="checkbox"/> Yes <input type="checkbox"/> No		CBC	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fasting Blood Sugar	<input type="checkbox"/> Yes <input type="checkbox"/> No		Thyroid Panel	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lipids (Cholesterol)	<input type="checkbox"/> Yes <input type="checkbox"/> No		Hearing Test	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemistry Panel	<input type="checkbox"/> Yes <input type="checkbox"/> No		Vision Test	<input type="checkbox"/> Yes <input type="checkbox"/> No
Urine Test	<input type="checkbox"/> Yes <input type="checkbox"/> No		TB (PPD) Test	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other (details):				

Family History

Question	Answer	Relationship to Child
1. Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Anesthetic Reaction	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Bleeding Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Cystic Fibrosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Cancer (and type)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Diabetes (type I or II)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7. Elevated Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	
8. Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	
9. Early/Unexplained Death	<input type="checkbox"/> Yes <input type="checkbox"/> No	
10. Muscular Dystrophy	<input type="checkbox"/> Yes <input type="checkbox"/> No	
11. Seasonal Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	
12. Sickle Cell Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	
13. Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	
14. Other (explain)	<input type="checkbox"/> Yes <input type="checkbox"/> 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 Physician Association, 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 Physician Association 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 Physician Association are sought for such child.

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

REQUIRED → **Signature of Primary Member:** _____ **Relationship to Child:** _____
Print Primary Name: _____ **Date of Completion:** _____
Person Completing Form: _____ **Relationship to Child:** _____

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

4100 Spring Valley, Ste 600, Dallas TX 75244