ARNOLD PALMER HOSPITAL
For Children
Supported by Arnold Palmer Medical Center Foundation

CENTER FOR ORTHOPAEDICS
HEALTH RECORD

LINE UP PATIENT I.D. LABEL HERE

❑ Orthopedic ❑ _____

Today's Date: _____ Pediatrician: _____ Referred by: _____
❑ Parent ❑ Guardian Name _____ Is this a second opinion: ❑ Yes ❑ No
Has the child seen one of our orthopedic doctors within the past 3 years? ❑ Yes ❑ No
If yes, was it the same problem? ❑ Yes ❑ No
Which emergency room do you use if your child required immediate treatment? _____

PROBLEM HISTORY

Child's age: _____ Date of first menstrual period: _____ ❑ N/A Allergies: _____
Why is your child being seen today? _____
When and how did the problem start? _____ How long does it last? _____ (e.g., 1 hour, 1 day)
Where is the problem area? _____ Is the problem getting (circle one): same better worse

Describe any pain the child is having: Circle level: Mild 0 1 2 3 4 5 6 7 8 9 10 Most Severe (worst)
Type of pain: ❑ Sharp ❑ Dull ❑ Throbbing
When is it painful? _____ What makes it better? _____
What makes it worse? _____ Any pain at night? _____
Symptoms of the problem (check all that apply): ❑ Numbness ❑ Tingling ❑ Bruising ❑ Pain goes somewhere else on body
How have you treated the problem? ❑ Ice ❑ Bracing ❑ Physical Therapy ❑ Chiropractor ❑ Medication: _____

PATIENT MEDICAL HISTORY

Does your child have a history of the following problems?

Cardiac (heart)	❑ Yes ❑ No	Ear, nose or mouth	❑ Yes ❑ No	Eye	❑ Yes ❑ No
Skin rash, sores or bruising	❑ Yes ❑ No	Endocrine (example Diabetes)	❑ Yes ❑ No	Psychiatric	❑ Yes ❑ No
Stomach or bowel	❑ Yes ❑ No	Immunology	❑ Yes ❑ No	Neurological	❑ Yes ❑ No
Musculoskeletal or arthritis	❑ Yes ❑ No	Hematology, Bleeding, Oncology	❑ Yes ❑ No	Seizures	❑ Yes ❑ No
Lung or breathing problems	❑ Yes ❑ No	Bladder	❑ Yes ❑ No		

Please explain any "Yes" answers: _____
Prior surgeries or hospitalizations: _____

FAMILY MEDICAL HISTORY

Arthritis	❑ Yes ❑ No	Hypertension	❑ Yes ❑ No	Muscular or bone disease	❑ Yes ❑ No
Cancer	❑ Yes ❑ No	Diabetes	❑ Yes ❑ No	Cardiac (Heart) Disease	❑ Yes ❑ No

Please explain any "Yes" answers: _____

DEVELOPMENT AND SOCIAL HISTORY

Birth: ❑ Full- term ❑ Premature Weeks of pregnancy _____ Birth weight:_____lb _____ oz
❑ Vaginal ❑ C-Section ❑ Head First ❑ Feet or bottom first (Breach) Length of infant hospital stay: _____

Age at first time: _____ Sitting _____ Crawling _____ Walking _____ Words _____ Toilet training
❑ Right handed ❑ Left handed Problems with using hands or fingers: _____

Sports Participation: _____
Participation in organized competition within the last year: _____
School: _____ Grade: _____ Usual report card grades: _____

QUESTIONS FOR THE DOCTOR

INTERPRETER ONLY

(Please Print)

Name: _____ Agency: _____

Telephone:_____ Language: _____

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FALLS ASSESSMENT *(Check all boxes that apply)*

Do you have any problems with your vision? ❑ Have you ever fallen due to a medical problem? If yes, when?_____

Do you have any of the following devices?

❑ Dental appliance ❑ Pulse oximeter ❑ central line ❑ vagal nerve stimulator ❑ Bi-level positive airway pressure
❑ CPAP ❑ ventilator ❑ cochlear implant ❑ myringotomy tubes
❑ continuous glucose monitoring ❑ sq Insulin Infusion Pump ❑ Implantable pump ❑ Baclofen pump

Do you have any history of falls/near falls? ❑ Yes ❑ No

Explanation of falls/near falls history

❑ Leg Braces ❑ A/B Monitor ❑ Wheelchair ❑ Other assistive devices _____

Pharmacy Name:_____

Address:_____

Phone Number:_____

Name of medication/vitamin/herbal preparations	DOSE	Initials	How often	Reason for taking	Length of time taken

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IMMUNIZATIONS/VACCINES

FOR CLINICAL STAFF: INITIAL IF PHYSICIAN REVIEW REQUIRED

Are the childhood immunizations up to date? ❑ Yes ❑ No
Are siblings immunizations up to date? ❑ Yes ❑ No

MDRO/Infectious Process Screen

History of MDRO (multi-drug resistant organisms), MRSA/VRE?
❑ No ❑ Yes - Initiate Contact Precautions ❑ unable to obtain/refused
Infectious Process Screen:
❑ No signs of infectious process ❑ Temp. 100.4 (38C) ❑ wounds with purulent drainage or erythema
❑ new onset cough with fever or new onset shortness of breath with fever ❑ signs of sepsis (Temp > 100.4 F (38 C) and hypotension ❑ Rash with Temp > 100.4 F (38 C)

_____
_____
_____

TUBERCULOSIS (T.B.) SCREENING

1. Pediatric (children younger than 12)

Does the child, any member of the household, or anyone who frequently visits the household have T.B.?
❑ No ❑ Yes – **(Inform the Front Desk immediately)**

_____

Does the child age 12 or greater (excluding Cystic Fibrosis patients), any member of the household, or anyone who frequently visits the household have a cough that has lasted longer than 2 weeks?
❑ No ❑ Yes – (Complete the Adult T.B. Assessment on the child or adult in question)
Adult's Name _____ Relationship to Patient _____

_____

2. Adult (check the box if the answer is YES. If the answer is NO, leave blank)

❑ Cough for longer than 2 weeks [3]
❑ Blood in the sputum [5]
❑ Fevers or night sweats [2]
❑ Recent unexplained weight loss of > 10 lbs [2]
❑ Recent exposure to T.B. [2]
❑ History of T.B. or active T.B. (even if on meds) [5]
❑ Jail in the past two years [2]
❑ HIV positive [2]
❑ Homeless or living in a shelter [1]
❑ Foreign born (Asia, E. Europe, Latin America, Africa) [1]

USE OF TOBACCO PRODUCTS

Do you smoke or use tobacco of any kind? ❑ No ❑ Yes*
If patient is a minor and does not smoke, does anyone living in the house with the patient smoke? ❑ No ❑ Yes*
*Would you like to receive information on how to stop using tobacco products? ❑ No ❑ Yes

USE OF DRUGS AND ALCOHOL PRODUCTS

Do you have a history of substance abuse? ❑ No ❑ Yes (complete questions below)
Type _____ Amount _____ Type _____ Amount _____
Type _____ Amount _____ Type _____ Amount _____

PSYCHOSOCIAL SCREENING

Do you feel safe at home? ❑ No ❑ Yes

ADVANCE DIRECTIVES – (COMPLETE ONLY IF OLDER THAN 18)

Do you have a Healthcare Surrogate? ❑ No ❑ Yes Do you have a Living Will? ❑ No ❑ Yes

SIGNATURE OF PERSON COMPLETING FORM: _____ Date:_____ Time:_____

STOP: OFFICE STAFF WILL COMPLETE BACK PAGE

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TO BE COMPLETED BY OFFICE STAFF	
Nursing/MOA Staff: Place your initials next to any "Yes" answers that require physician review	
INSTRUCTIONS	
IMMUNIZATIONS	If current per parent/guardian, verify on Vaccine Administration Record (VAR) (General Pediatrics Only)
CONTAGIOUS DISEASES	If "Yes" to any of these notify clinical staff immediately so an RN or physician can triage to determine possible transmission risk.
IF A HISTORY OF MRSA/VRE	Initiate MRSA/VRE Protocol orders #5872-96739
TUBERCULOSIS (T.B.) SCREENING	**Pediatric [younger than 12] – if "Yes" to this**, notify clinical staff immediately so an RN or physician can triage to determine possible transmission risk. **Adults [12 and older] – add up points:** Total points _____ If the patient has received 5 or more points, place a T.B. mask on the patient and place in a private room, using Airborne precautions. Contact the physician for an assessment.
USE OF TOBACCO	If a patient answers yes to: *Would you like to receive information on **PRODUCTS** how to stop using tobacco products?" offer the **TIPS TO KICK TOBACCO** booklet through Smartworks (4767-46341).
PSYCHOSOCIAL SCREENING	*Any "No" answer must be addressed. Refer to Corporate P&P that details the requirements for healthcare workers.* **SUSPECTED CHILD, ELDERLY, OR MENTALLY HANDICAPPED** **ABUSE OR NEGLECT: IDENTIFICATION AND REPORTING #1600** **SUSPECTED DOMESTIC VIOLENCE REPORTING (ADULT) #1625** **Abuse Hotline: 1-800-96-ABUSE**
FALLS ASSESSMENT	If any special assist devices are checked, patient is increased risk for falls. Make sure the environment is safe and free of obstructions.

For Office Use

Nursing/MOA Review:_____ Title _____ Date _____ Time _____

Physician/Practitioner:_____ I.D.# _____ Date _____ Time _____