ORLANDO HEALTH® | ARNOLD PALMER HOSPITAL For Children

PEDIATRIC SPECIALTY PRACTICE

LINE UP PATIENT I.D. LABEL HERE

HEALTH RECORD

❑ Craniofacial ❑ Pulmonology ❑ Gastroenterology ❑ Nephrology ❑ Endocrine ❑ Genetics ❑ Rheumatology
❑ Spina Bifida ❑ Infectious Disease ❑ Neurosurgery ❑ Neuropsychology ❑ _____

Date:_____ Completed by: ❑ Patient ❑ Parent/Guardian ❑ Other _____

Primary Care Physician _____ Phone Number _____

PLEASE COMPLETE THE FOLLOWING SECTIONS AS FULLY AS POSSIBLE

ALLERGIES

Are you ALLERGIC to any medications, food, or other? ❑ No ❑ Yes/List all ALLERGIES and describe your reaction:

_____

_____

CURRENT MEDICAL HISTORY

What health problem has brought you here today (reason for visit)? ❑ Check-up ❑ Problem (please list)

_____

When did this problem start? _____

How long does it last? _____ (exp: 1 hour, 1 day) Where is the problem area? _____

Is the problem getting: ❑ same ❑ better ❑ worse

Have you received any treatment for this problem? ❑ No ❑ Yes/List type of treatment and where and when received:

_____

Date/Age of first menstrual period: _____

PAIN: Do you have any ongoing pain problems? ❑ No ❑ Yes Do you have pain now? ❑ No ❑ Yes

PAST MEDICAL AND SURGICAL HISTORY

Please check **ALL** previous illnesses or conditions below.

❑ Heart problems	❑ Heart murmur	❑ Lung problems	❑ Asthma	❑ Mental illness
❑ High blood pressure	❑ Liver problems	❑ Stomach problems	❑ Stroke	❑ Seizures
❑ Circulation problems	❑ Neurological problems	❑ Bone pain/problems	❑ Cancer	
❑ Kidney/urine problems	❑ Bleeding problems	❑ Thyroid problems	❑ HIV/AIDS	
❑ Diabetes or sugar in urine	❑ Sexually transmitted disease	❑ Muscle weakness/Musculoskeletal problems		

❑ Recent weight loss/gain. ❑ No ❑ Yes If yes, how much? Loss _____ Gain _____

❑ Other: _____

Please provide more information below for any of the conditions or illnesses you checked above.

_____

_____

List **ALL** past surgeries and procedures (Include type of surgery and date):

_____

_____

_____

_____

_____

FAMILY MEDICAL HISTORY

Please check **ALL** illnesses or conditions below that run in your family (blood relatives).

❑ Heart problems	❑ Heart murmur	❑ Lung problems	❑ Asthma	❑ High blood pressure
❑ Liver problems	❑ Stroke	❑ Circulation problems	❑ Bleeding problems	❑ Stomach problems
❑ Mental illness	❑ Seizures	❑ HIV/AIDS	❑ Cancer	❑ Thyroid problems
❑ Kidney/urine problems		❑ Bone pain/problems	❑ Neurological problems	
❑ Diabetes or sugar in urine		❑ Muscle weakness/Musculoskeletal problems		❑ Other: _____

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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 _____

DEVELOPMENT AND SOCIAL HISTORY

Birth: ❑ Full-term ❑ Premature Weeks of pregnancy _____ Birth Weight ____lb _____oz.
❑ Vaginal ❑ C-Section ❑ head first ❑ Feet or bottom first (Breech) 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: _____ ❑ None
Sports Participation: _____ Favorite Activities: _____
School: _____ Grade:_____ Usual report card grades: _____

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

Parent/ Legal Guardian Signature _____ Date_____ Time_____

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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 F (38 C) ❑ wounds with purulent drainage or erythema

_____

❑ new onset cough with fever or new onset SOB with fever ❑ signs of sepsis (Temp > 100.4 F (38 C) and hypotension ❑ Rash with Temp > 100.4 F (38 C)

_____

TUBERCULOSIS (TB) SCREENING

1. Pediatric (children younger than 12)

Does the child, any member of the household, or anyone who frequently visits the household have TB?

_____

❑ 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 TB 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]	❑ History of TB or active TB (even if on meds) [5]
❑ Blood in the sputum [5]	❑ Jail in the past two years [2]
❑ Fevers or night sweats [2]	❑ HIV positive [2]
❑ Recent unexplained weight loss of > 10 lbs [2]	❑ Homeless or living in a shelter [1]
❑ Recent exposure to TB [2]	❑ 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: _____

For Office Use

Nursing/MOA Review:_____ Title_____ Date _____Time_____
Physician/Practitioner:_____ I.D.#_____ 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 (TB) 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 TB 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.