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

PEDIATRIC SPECIALTY PRACTICE

HEALTH RECORD

❑ Craniofacial ❑ Orthopedic
❑ Endocrine ❑ Pulmonology
❑ Gastroenterology ❑ Rheumatology
❑ Nephrology ❑ Spina Bifida
❑ _____

LINE UP PATIENT I.D. LABEL HERE

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

PLEASE COMPLETE THE FOLLOWING SECTIONS AS FULLY AS POSSIBLE

Preferred Language _____ Preferred learning style: ❑ Verbal ❑ Printed material ❑ _____
Barriers to Learning ❑ No ❑ Yes/List _____

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

_____

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.

❑ Premature birth ❑ No ❑ Yes/How many weeks _____ Birth weight _____

❑ 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	❑ HIV/AIDS
❑ Kidney/urine problems	❑ Bleeding problems	❑ Thyroid problems	❑ Muscle weakness/ Musculoskeletal problems	
❑ Diabetes or sugar in urine	❑ Sexually transmitted disease			

❑ 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		

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 weaknesses in your muscles that may cause you to fall?
❑ Do you have any breathing problems? ❑ Do you take any medicines that make you feel dizzy?
Do you use any of the following: ❑ Hearing Aid ❑ Pacemaker ❑ Crutches ❑ Glasses/Contacts ❑ Walker
❑ Leg Braces ❑ A/B Monitor ❑ Wheelchair ❑ Other assistive devices _____

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HEALTH RECORD

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 child's vaccines current? ❑ Yes ❑ No

Adult Vaccines: Have you had any of the following vaccines?

Hepatitis B Series ❑ No ❑ Yes/Year #1_____ #2_____ #3_____ Flu ❑ No ❑ Yes/Year _____

Pneumococcal ❑ No ❑ Yes/Year _____ Tetanus ❑ No ❑ Yes/Year _____

CONTAGIOUS DISEASES

Has the patient (or anyone that lives in the same household as the patient) had any of the following:

1. A history of MRSA or VRE infection? ❑ No ❑ Yes: Treated?_____When?_____ _____
2. Recent exposure to chicken pox, shingles, scabies or lice? ❑ No ❑ Yes _____ _____
3. Any other infectious (contagious) disease? ❑ No ❑ Yes (Specify)_____ _____

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: Explain any **Yes** answers

Do you have any behavioral and/or mental health concerns? ❑ No ❑ Yes _____

Do you have any special religious and/or spiritual needs? ❑ No ❑ Yes _____

Do you need additional emotional support during this visit? ❑ No ❑ Yes _____

Is there any history of or current sexual, emotional, or physical abuse? ❑ No ❑ Yes _____

Is there any history of or current domestic violence? ❑ 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 "Yes" 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.