

Pediatric (0-17yrs.) Patient/Family Information

(All sections need to be complete by patient/significant other. Use black ink. Check yes or no and answer each question.)

STAFF USE ONLY: (Check entity) PH PHM SDSC POH Northpoint

(Ask patient/significant other the following and access interpreter if needed:)

Do you have any problems reading, hearing, speaking or writing English?

If yes, describe: _____

STAFF USE ONLY: Vital Signs: T _____ P _____ R _____ BP _____ Ht. _____ Wt. _____

GENERAL INFORMATION (Refer to Infection Control)

1. What symptom(s) is your child having now (include rashes, cough, fever, etc.)? _____

2. When did the symptoms begin? _____

3. Does your child have a doctor he/she sees regularly? Yes No

If yes, name of doctor / group: _____

4. Are there other doctors that care for your child? Yes No

If yes, please list: _____

5. Do you have any special needs / requests for you or your family? Yes No

(For example: use of blood products, limited visitors, religious / cultural practices, emotional issues, or other concerns)

If yes, how may we assist you? _____

6. **Has your child had a recent (2 weeks) exposure to any infections / contagious diseases?** Yes No

If yes, what? _____

7. Does your child have pain now? Yes No If yes, please answer the following:

Where is your child's pain? _____

Ask your child to rate his/her pain using one of the following scales:

A. Circle the face that shows how you feel:



OR

B. Rate your pain from 0 (none) to 10 (worst possible) _____

What makes your child's pain better? (i.e. medications, etc.) _____ worse? _____

How does your child's pain affect their:

Sleep _____
 Appetite _____
 Physical Activity _____
 Other _____

Emotions _____
 Ability to Concentrate _____
 Relationship w/ Others _____

FAMILY HISTORY (Check if the child has a family history of the following: include child's parents, siblings and grandparents only)

- | | |
|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Lung disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart problems |
| <input type="checkbox"/> TB | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Drug Addiction |
| <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Liver/stomach problems |
| <input type="checkbox"/> Kidney / urinary problems | <input type="checkbox"/> Problems with anesthesia |
| <input type="checkbox"/> Other: _____ | |

CHILD'S MEDICAL HISTORY (Check if the child has been diagnosed with the following):

- | | |
|--|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart problems |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Lung disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Immune disorder |
| <input type="checkbox"/> TB | <input type="checkbox"/> Bleeding problems |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Learning disability |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Chicken Pox |
| <input type="checkbox"/> Birth defects | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Kidney / urinary problems | <input type="checkbox"/> Hearing/vision problems |
| <input type="checkbox"/> Stomach/ liver problems | <input type="checkbox"/> Psychiatric conditions |
| <input type="checkbox"/> Date of last period _____ | |
| <input type="checkbox"/> Other: _____ | |

Explain any items checked: _____

BIRTH HISTORY

Was your child admitted to an Intensive Care Nursery (ICN) at birth or were there any complications at birth? Yes No

Reason/Complication: _____

Number of days in ICN: _____ Birth weight: _____

IMMUNIZATIONS

Are your child's immunizations up-to-date? Yes No

If not, explain _____



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CHILD LIFE

Where does your child go to school? _____ Grade _____
 Does your child attend day care? Yes No If yes, place: _____
 Favorite games/activities: _____

MEDICATIONS – Prescription, Non-prescription, Patches/Ointments, Vitamins, Herbals and Allergies

List all medications the child is presently taking and all allergies and reactions.

<input type="checkbox"/> None Name	Dose	Times per day	Reason/Medical Condition	Last Dose	<input type="checkbox"/> None ALLERGIES/REACTIONS (Food, medicine, tape, latex, etc.)

Has your child received any additional medications in the last 24 hours (not listed above?) Yes No

If yes, explain: _____

Location of medications: Left at home Given to nurse
 Sent home with _____ (name/relationship) Other _____

NUTRITION (Refer to Nutrition Services)

Has your child experienced any unintentional weight loss in the past 3 months? Yes No

Does your child have any physical problems that make it hard to eat? (ex: chewing, swallowing, diarrhea, vomiting, mouth sores) Yes No

Has your child had a poor appetite or eaten half as much as normal for the past 3 days or longer? Yes No

Does your child have any diet restrictions? If yes, explain: _____ Yes No

What formula do you use? _____ Amount: _____ Frequency: _____

Does child use - Breast Cup Tube feeding _____ Type of feeding tube

FUNCTIONAL ABILITY / SPECIAL NEEDS:

(Check as applicable to child: (Refer to Medical Resource Management))

Is your child's behavior/development typical for their age? Yes No

If no, explain: _____

Is your child toilet trained? Yes No

day night both

Is there anything specific or unique about your child that you would like to tell us? (i.e. uses pacifier, sleeps with night light, naps, bedtime routine, comfort measures, fears) Yes No

Does your child receive special services? Yes No

Physical Therapy Special Education

Speech Therapy Psychologist

Occupational Therapy

Home Nursing Name of agency: _____

Does your child use any of the following?

Glasses/contacts Oral braces/retainer

Hearing aid Oxygen

Nebulizer Apnea Monitor

Urinary catheters and size _____

Wheelchair/special chair, crutches, walker

Central line and type: _____

Ostomy Infusion port

Other: _____

Staff use only – Referrals made to the following:

	Date	Initial	Date	Initial
Medical Resource Mgt.	_____	_____	_____	_____
Infection Control	_____	_____	_____	_____
Nutrition	_____	_____	_____	_____
Rehabilitation	_____	_____	_____	_____

If referral(s) not needed at this time, circle discipline and state reason: _____

DISCHARGE PLANNING/FAMILY SUPPORT

(Refer to Medical Resource Management)

Who is child's legal guardian? Parents Other _____

Will a family member/guardian be staying with the child in the hospital? Yes No

Has your child missed taking any medications or treatments because you are unable to pay for them? Yes No

If yes, describe: _____

Would you like to speak with any of these individuals during your stay?

Business Office Case Manager/Social Worker

Chaplain/Counselor Other: _____

To the best of my knowledge, this information is complete and accurate.

PATIENT/FAMILY SIGNATURE:

(Given relationship if not patient): _____

Information incomplete due to: _____

Pre-admission Staff Signature/Date: _____

Staff Signature/Date/Time: _____

Reviewed/Completed:

Changes	Patient/Family Signature/Date	Staff Signature / Date/Time
<input type="checkbox"/> Y <input type="checkbox"/> N	_____	_____

Changes	Patient/Family Signature/Date	Staff Signature / Date/Time
<input type="checkbox"/> Y <input type="checkbox"/> N	_____	_____

