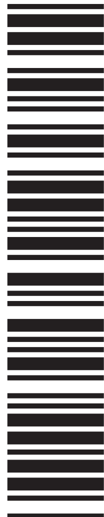

MR9P1

Epworth

PATIENT HEALTH HISTORY - PAEDIATRIC

Affix Patient Identification Label

Unit Record Number ....

Surname ....

Given name ....

D.O.B. .... Age .... Sex..........

Medical Practitioner ....

HEALTH INFORMATION

Full name:

Child's preferred name:

Date of birth:

Reason for admission:

Date form completed:

Has your child had surgery? ☐ Yes ☐ No
If yes, specify:

Medical history:

Are your child's immunisations up to date? ☐ Yes ☐ No
If no, what is not in date?

Height: cm Weight: kg

Head circumference: cm

Primary language spoken:

Does your child require an interpreter? ☐ Yes ☐ No

Blood tests taken for this admission? ☐ Yes ☐ No
Company & date taken: ____________________

X-rays taken for this admission? ☐ Yes ☐ No

Nutrition Information

Does your child require a specific diet? ☐ Yes ☐ No
Please specify: ____________________

Is your child having any formula and/or breastfeeding (please circle)? ☐ Yes ☐ No

Does your child have speech or swallowing difficulties? ☐ Yes ☐ No
If yes, specify:

What time does your child go to bed? Time:
What time does your child wake up? Time:

LIFESTYLE

Does your child have a comfort object? ☐ Yes ☐ No
(i.e. dummy, toy)
Please specify:

Is your child at school? ☐ Yes ☐ No
If so what year are they in? ____________

Does your child attend childcare? ☐ Yes ☐ No

ALLERGIES

Any Allergies to:	if 'yes', please specify:
☐ No known allergies	
☐ Anaesthetics (self/family) Specify medications involved.	
☐ Blood products	
☐ Chemotherapy	
☐ Food	
☐ Medication	
☐ Rubber/latex	
☐ Tapes/lotions	
☐ Other	

HEALTH HISTORY

Answer all questions about your child and circle as needed:

Behavioural Issues ☐ Yes ☐ No
If yes, specify management:

Born premature __________ weeks ☐ Yes ☐ No

Diabetes: Type 1 / Type 2 ☐ Yes ☐ No

Eczema ☐ Yes ☐ No

Intellectual disability/learning difficulties ☐ Yes ☐ No
If yes, specify: ____________________

Kidney condition ☐ Yes ☐ No

Liver condition ☐ Yes ☐ No

Cough, cold or sore throat (last 2 weeks) ☐ Yes ☐ No

Epilepsy/ fits/ seizures ☐ Yes ☐ No
Date of last seizure: ____________________

Psychiatric problems (anxiety/ depression) ☐ Yes ☐ No

Heart conditions ☐ Yes ☐ No
If yes, specify interventions:
____

Blood/ Clotting problems (self or family) ☐ Yes ☐ No
Please specify: ____________________

Breathing problems (sleep apnoea) ☐ Yes ☐ No

Asthma ☐ Yes ☐ No

Reflux ☐ Yes ☐ No

Is your child toilet trained? ☐ Yes ☐ No
Does your child wear nappies? ☐ Day ☐ Night ☐ N/A

Constipation/diarrhoea ☐ Yes ☐ No

Bladder problems/ incontinence ☐ Yes ☐ No

Physical disability/ mobility issues ☐ Yes ☐ No
How does your child mobilise?
☐ walk ☐ crawl ☐ mobility aide ☐ carried

Impairment: vision/hearing ☐ Yes ☐ No
Aids used? ____________________

Hospitalization overseas within last 12 months ☐ Yes ☐ No

Does your child have any implanted devices:

Baclofen pump ☐ Yes ☐ No

Cochlear implant ☐ Yes ☐ No

Insulin pump ☐ Yes ☐ No

ICD (implanted defibrillator) ☐ Yes ☐ No

Vagal nerve stimulator ☐ Yes ☐ No

Permanent pacemaker ☐ Yes ☐ No

Other implants ☐ Yes ☐ No

Please specify: ____________________
____

Does your child or family have a history of malignant hyperthermia? ☐ Yes ☐ No

History of multi resistant bacterial infection (e.g. MRSA/VRE/CRE/ESBL) ☐ Yes ☐ No

History of chicken pox or vaccination ☐ Yes ☐ No

History of measles or vaccination ☐ Yes ☐ No

PATIENT HEALTH HISTORY - PAEDIATRIC MR9P1

Epworth

PATIENT HEALTH HISTORY - PAEDIATRIC

Affix Patient Identification Label

Unit Record Number ....

Surname ....

Given name ....

D.O.B. .... Age .... Sex...........

Medical Practitioner ....

MEDICATIONS

Please list ALL medications your child is currently taking: prescribed, over the counter & complementary medicine (including vitamins & supplements):

Medication	Dose	Frequency	Hospital Use Only: Brought in?	Hospital Use Only: Last taken?	Medication	Dose	Frequency	Hospital Use Only: Brought in?	Hospital Use Only: Last taken?

Please bring all of your child's listed medications with you in the original packaging, as well as any repeat/authority prescriptions, safety net and concession cards.

Has your child been instructed to stop any medications prior to their admission? ☐ Yes ☐ No

Has your child taken any steroids or cortisone tablets or injections in the last 6 months? ☐ Yes ☐ No

Is your child taking Clopidogrel, Aspirin, Warfarin (Coumadin) or any other blood-thinning medications? ☐ Yes ☐ No
If so, has your child been given instructions about stopping them before the surgery or procedure? ☐ Yes ☐ No

PASTORAL CARE

Would you and/or your child like pastoral care support or counselling? ☐ Yes ☐ No
Do you and/or your child have any religious requirements?

DISCHARGE PLAN

Who else lives in your house besides yourself and your child? (Please specify ages of other children if any)

If your child is required to stay overnight, who will be staying with your child?

How long do you expect to be in hospital? __________ days

Where do you plan to go after discharge? ☐ Home ☐ Rehab ☐ Other (please specify): ____________________________

VALUABLES

PLEASE DO NOT BRING ANY VALUABLES INTO HOSPITAL

I am aware that any valuables (including jewellery, cash, credit cards, computer equipment, mobile phones or other items of personal property with a high monetary value) I bring to hospital or decide to keep with me during my admission are my responsibility and I understand that the hospital is not liable for any losses of my personal property.

Name:____ Signature: ___________________________ Date: _________________

HOSPITAL USE ONLY: REFERRALS

Initial and date	Referral	Review		Referral	Review		Referral	Review
Anaesthetist			Paediatrician			Speech Therapy		
Diabetes Educator			Pastoral Care			Other:		
Dietitian			Physiotherapy					

Note: All staff actioning a referral must document the assessment in the appropriate location in the medical history

Preadmission nurse name:		Signature:		Designation:		Date:	
Admitting nurse name:		Signature:		Designation:		Date & time admitted:	

ADDITIONAL COMMENTS

-Check the MR1 Admission Details for Medical Treatment Decision Maker or Medical Power of Attorney information.

- Update A1 Alert Card & iPM (eg: ACD, Medical Treatment Decision Maker, Allergies)

MR9P1 PATIENT HEALTH HISTORY - PAEDIATRIC