Pediatric Services
Part B

Name: _____
Date: _____
DOB: _____

Office use only:
MR#_____

Part A reviewed with family and updated appropriately ☐ Yes ☐ No

IMMUNIZATION HISTORY

Immunizations up to date? ☐ Yes ☐ No ☐ Unknown
Copy in chart ☐ Yes ☐ No, If No requested ☐ Yes ☐ No _____

If not up to date, reason for non-immunization: ☐ religious ☐ medical ☐ other:_____
_____
_____

Have you traveled outside the United States in the last 7 years? ☐ Yes ☐ No
If yes where did you travel?_____How long was the trip?_____

ALLERGIES / SENSITIVITIES

List any type of allergies the patient has experienced (food, medication, blood transfusion, anesthesia, latex, environmental) and the type of reaction experienced.
Allergies / Reaction:_____
_____
_____
_____
_____

Latex Allergy Screen: Has the patient ever had a reaction, itching or difficulty breathing when exposed to latex rubber materials like gloves, condoms, balloons or food such as bananas, avocados, papaya, kiwi fruit?
☐ Yes ☐ No (what happened)?_____
_____
Any member of the patient's family allergic to latex or have they ever had a reaction to the material or food listed above? ☐ Yes ☐ No (what happened)?_____
_____

NUTRITION AND ELIMINATION

Is the patient able to eat and drink without help?
☐ Yes ☐ No. No, describe help or utensils needed?_____
Does the patient have a G-Tube? ☐ Yes ☐ No Formula used?_____
Please describe the patient's diet and regular eating schedule:_____
_____
Favorite Foods:_____
Least Favorite:_____
Are there any foods that the patient cannot tolerate?_____
Are there any restrictions? (Kosher, special diet):_____
Does the patient have difficulty swallowing? ☐ Yes ☐ No ☐ Left side ☐ right side ☐ Liquids ☐ Solids
Is the patient able to control their bowel movements? ☐ Yes ☐ No
Does the patient have a regular bowel routine?_____
Does the patient have bladder control? ☐ Yes ☐ No
How often does the patient urinate?_____
Is the patient toilet trained? ☐ Yes ☐ No Does the patient need help with toileting? ☐ Yes ☐ No
Does the patient have a history of:
☐ Bedwetting ☐ Blood in urine ☐ Urinary Infections ☐ Urinary Retention ☐ Incontinence
If the patient has bladder problems, do they need to wear diapers?
☐ Yes ☐ No If yes, size?_____

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Does the patient need a catheter? ☐ No ☐ Yes
What size catheter is used?_____
☐ Intermittent Catheterization What is the schedule of catheterization_____
Who does it? ☐ Patient ☐ Parent/Caregiver
☐ Indwelling Catheter When was the catheter changed last?_____
By whom:_____
☐ Self-Catheterization? Or by whom:_____

HYGIENE, REST, AND ACTIVITY

Does the patient prefer: ☐ Bath ☐ Shower
Describe any assistance needed:_____
How frequently does the patient brush their teeth?_____
Is help needed (describe)?_____
Does the patient have any sleeping problems?
☐ None ☐ Early Waking ☐ Insomnia ☐ Nightmares ☐ Sleep walking
Is there fear of darkness? ☐ Yes ☐ No ☐ Sometimes
How many hours a night does the patient sleep?_____Bed time?_____Nap times?_____
Tell us about favorite play/recreational habits:_____
Favorite toy/game?_____

PSYCHOSOCIAL RELATIONSHIPS AND DISCHARGE PLANNING

Does the patient have siblings?

Name	Age	Live at home?
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

What is the preferred religion?_____
Does the patient interact well with peers? ☐ Yes ☐ No Difficulties:_____
How does the patient respond to strangers?_____
Are you or the patient in a relationship in which you have been hurt or frightened? ☐ Yes ☐ No
Has anyone verbally or physically threatened you, the patient, or someone you love? ☐ Yes ☐ No
Has the patient ever considered suicide? ☐ Yes ☐ No
If yes to the above questions, would you consider help at this time? ☐ Yes ☐ No
Comment:_____

Special considerations that may affect learning: ☐ None
☐ Language ☐ Fatigue/pain ☐ Hearing/vision/speech impairment ☐ Psychological factors
☐ Cognitive limitation/developmental level ☐ Cultural ☐ Religious implications

Name of person completing this form_____Relation to patient_____

Patient or Guardian's Signature_____Date_____

Reviewed by:_____Date_____