Sydney Adventist Hospital

PAEDIATRIC PATIENT HISTORY

This form can be completed online at https://eadmissions.sah.org.au

MRN	ACN
Family Name	Given Name(s)
Date of birth	Phone No.
Sydney contact phone no.	Mobile No.
Admission Date 2 0	Admitting Doctor

PATIENT HISTORY *(Please circle or tick the relevant answers and specify details where indicated)* NB: Shaded area Staff Only

Please specify reason for admission

Does your child understand why he / she is in hospital? ☐Yes ☐No

Is this admission the result of a past or present injury? ☐Yes ☐No

If **yes**, what was the cause of injury?

Place (eg school, home)

Date of injury / /

Does your child have a nickname or preferred name?

Patient being admitted from: ☐Home ☐Doctor's office ☐Emergency Care ☐Other

Do you wish to have any restrictions on: Visitors? ☐Yes ☐No Telephone? ☐Yes ☐No

At which hospital was your child born?

Summary of previous history or previous hospitalisation

Year	Illness / Surgery	Place (if applicable)

Staff Only

Problems with anaesthesia

Malignant Hyperthermia	N	Y	If **yes**, ☐Your child ☐Family
Other	N	Y	Specify.....
Are your child's Immunisations up to date?	N	Y	Unsure
Complaint of pain	N	Y	State type Location
Has your child recently had a cough, cold or contact with infectious disease?	N	Y	Specify
Any Limitations	N	Y	☐Vision ☐Hearing ☐Speech ☐Other
Sensory Aids	N	Y	☐Glasses ☐Contact Lenses ☐Dental braces / devices ☐Other.....

☐If yes, notify Anaesthetist

Staff Only

Please tick if your child has ever had:
☐Asthma ☐Croup ☐Bronchiolitis ☐Measles ☐Diabetes
☐Mumps ☐Chickenpox ☐Rheumatic fever ☐Heart disease ☐Hepatitis
☐Anaemia ☐Blood transfusion ☐Jaundice ☐Convulsions

Does your child, or any relatives, have Creutzfeldt-Jakob Disease (CJD)?	N	Y
Does your child have a 'medical in confidence' letter regarding CJD?	N	Y
Does your child have an unexplained progressive neurological illness in the last 12 months?	N	Y

☐If yes, staff to notify Bookings on x9908

Paediatric Patient Allergies & Sensitivities

Please document any known allergies or sensitivities eg. medications, latex, plants, tape.

Allergies	Sensitivities	Reaction

Staff Only

Food allergy ☐Diet office contacted

Paediatric Patient Current Medications

Regular pharmacy: Name Contact no.

Please record details of all your child's current medications, which would include tablets, capsules, puffers, patches, injections, insulins, eye drops and creams.

Consult your GP or specialist(s) if you are unsure of any details about your child's medications or which medications should be ceased prior to surgery.

Bring into hospital ALL current medications your child is taking (in original containers); also any PBS Authority prescriptions for current medications and PBS entitlement cards.

Non-prescription medication eg. complementary therapies, natural therapies, herbal preparations or vitamins, please specify.

Prescription & Non-Prescription Medications	Strength	Route (eg.oral)	Dose	Frequency	For Long Stay Patients Only: Last taken	Brought in by patient

Staff Only

Has patient brought own stock (including complementary therapies) to hospital? ☐Yes ☐No ☐N/A

If Yes ☐Sent home ☐Schedule 8 cupboard ☐Patient medication drawer

PAEDIATRIC PATIENT HISTORY

MR 26B

MR26BP1

PAEDIATRIC PATIENT HISTORY (Continued)

MRN .....

Family Name .....

Given Name(s) .....

DOB .....

Social History

Mother's name		Father's Name	
Brothers	Age	Sisters	Age
	Age		Age

Does your child have a favourite toy/cuddly? N Y Will they bring it with them? ☐ No ☐ Yes

What activities does your child enjoy? (eg. puzzles, books, iPad)

Family History (Indicate relationship of person to patient)

☐ Asthma	☐ Sleep apnoea	☐ Bleeding tendency
☐ Eczema	☐ Diabetes	☐ Other
☐ Allergies	☐ Heart disease	☐ SIDS

Staff Only

Patterns of Daily Living

If your child wears nappies, what size .....

Personal Hygiene		☐ Shower ☐ Bath ☐ Baby Bath	
Does your child need assistance with cleaning his / her own teeth?	N	Y	
Any problems with bowel function?	N	Y Give details	
Any problems with bladder function?	N	Y Give details	
Does your child use any special words when wanting to use the toilet?	N	Y Give details	
Sleep — Any sleep problems?	N	Y Specify	

Sleep — Sleeps in : ☐ Bed ☐ Cot | Normal hours of sleep ☐ Hrs | Usual bedtime | Child likes a light on whilst sleeping. ☐ Yes ☐ No

Staff Only

Dietary Requirements

Does your child have a special diet? ☐ No ☐ Yes

If **yes**, specify .....

☐ Diet office contacted

Generally children under 12 years are not supplied with hot drinks unless specified by a parent.

For SMALL CHILDREN	**FOOD**	☐ Mashed ☐ Strained ☐ Normal	What and how much?
	FLUID	☐ **Breastfed**	Times
		☐ **Bottle**	Type of teat
			Type of formula — How much?
Does your child have a dummy? ☐ Yes ☐ No		☐ **Other fluids**	☐ Feeding cup ☐ Glass

Valuables (Staff Only) *Whilst all care will be taken SAH does not accept responsibility for valuables or personal belongings.*

Personal property ☐ N / A ☐ Kept at own / parents' risk ☐ Ward storage ☐ Taken home by .....(sign.)

Valuables ☐ N / A ☐ Kept at own / parents' risk ☐ Ward storage ☐ Taken home by .....(sign.)

Patient / Carer to sign .....

Orientation to Ward / Explanations to patient / parent (Staff Only)

	Init.		*Init.*
Room & ward orientation eg. lighting, bathroom, toilet.		Communication system eg. telephone, TV, nurse call	
Parent facilities eg. kitchen, room		Consent form completed. Medical assessment arranged	

Name of Admitting Nurse

Signature ..... Print Name ..... Designation ..... Date ...../...../20.....

SIGNATURE

I have carefully read all the above and I certify that the information I have given is correct and true to the best of my ability.

Signature .....

Date ...../...../20.....

Form completed by:

Patient ...../Sign.

Carer ...../Sign.

Guardian ...../Sign.

Nurse ...../Sign.

MR26BP2