11 years

Please complete these forms before your visit today.

Thank you!

GARDNER
Packard Children's Health Center

SPORTS HISTORY FORM

Formulario de historial clínico para participación de deportes

Name/ *Nombre*: _____

Date of birth/ *Fecha de nacimiento*:: _____

Sport(s)/*Deporte(s):* _____

QUESTIONS ABOUT THE ATHLETE/PATIENT - PREGUNTAS SOBRE EL ATLETA/PACIENTE

List past and current medical conditions
Mencione los padecimientos médicos pasados y actuales que haya tenido:

Have you ever had surgery? If yes, list all past surgical procedures
Alguna vez se le practicó una cirugía? Si la respuesta es afirmativa, haga una lista de todas sus cirugías previa:

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional)
Medicamentos y suplementos: Enumere todos los medicamentos recetados, medicamentos de venta libre y suplementos (herbolarios y nutricionales) que consume.

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects)
¿Sufre de algún tipo de alergia? Si la respuesta es afirmativa, haga una lista de todas sus alergias (por ejemplo, a algún medicamento, al polen, a los alimentos, a las picaduras de insectos).

For the following questions, explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)
Para las siguientes preguntas, dé una explicación para las preguntas en las que contestó "Sí", en la parte final de este formulario. Encierre en un círculo las preguntas si no sabe la respuesta).

GENERAL QUESTIONS ABOUT THE ATHLETE/PATIENT - PREGUNTAS GENERALES SOBRE EL ATLETA/PACIENTE			
1	Do you have any concerns that you would like to discuss with your provider? *¿Tiene alguna preocupación que le gustaría discutir con su proveedor de servicios médicos?*	Yes Sí	No
2	Has a provider ever denied or restricted your participation in sports for any reason? *¿Alguna vez un proveedor de servicios médicos le prohibió o restringió practicar deportes por algún motivo?*	Yes Sí	No
3	Do you have any ongoing medical issues or recent illness? *¿Padece algún problema médico o enfermedad reciente?*	Yes Sí	No

HEART HEALTH QUESTIONS ABOUT THE ATHLETE/PATIENT - PREGUNTAS SOBRE EL SALUD CARDIOVASCULAR DEL ATLETA/PACIENTE			
4	Have you ever passed out or nearly passed out during or after exercise? *¿Alguna vez se desmayó o estuvo a punto de desmayarse mientras hacía, o después de hacer, ejercicio?*	Yes Sí	No
5	Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? *¿Alguna vez sintió molestias, dolor, compresión o presión en el pecho mientras hacía ejercicio?*	Yes Sí	No
6	Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise? *¿Alguna vez sintió que su corazón se aceleraba, palpitaba en su pecho o latía intermitente- mente (con latidos irregulares) mientras hacía ejercicio?*	Yes Sí	No
7	Has a doctor ever told you that you have any heart problems? *¿Alguna vez un médico le dijo que tiene probleemas del corazón?*	Yes Sí	No
8	Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography. *¿Alguna vez un médico le pidió que se hiciera un examen del corazón? Por ejemplo, electro- cardiografía (ECG) o ecocardiografía.*	Yes Sí	No
9	Do you get light-headed or feel shorter of breath than your friends during exercise? *Cuando hace ejercicio, ¿se siente mareado o siente que le falta el aire más que a sus amigos?*	Yes Sí	No
10	Have you ever had a seizure? *¿Alguna vez tuvo convulsiones?*	Yes Sí	No

HEART HEALTH QUESTIONS ABOUT YOUR FAMILY - PREGUNTAS SOBRE LA SALUD CARDIOVASCULAR DE SU FAMILIA			
11	Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)? *¿Alguno de los miembros de su familia o pari- ente murió debido a problemas cardíacos o tuvo una muerte súbita e inesperada o inexplicable antes de los 35 años de edad (incluyendo muerte por ahogamiento o un accidente auto- movilístico inexplicables)?*	Yes Sí	No
12	Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic poly- morphic ventricular tachycardia (CPVT)? *¿Alguno de los miembros de su familia padece un problema cardíaco genético como la mio- cardiopatía hipertrófica (HCM), el síndrome de Marfan, la miocardiopatía arritmogénica del ventrículo derecho (ARVC), el síndrome del QT largo (LQTS), el síndrome del QT corto (SQTS), el síndrome de Brugada o la taquicardia ven- tricular polimórfica catecolaminérgica (CPVT)?*	Yes Sí	No
13	Has anyone in your family had a pacemaker or an implanted defibrillator before age 35? ¿Alguno de los miembros de su familia utilizó un marcapasos o se le implantó un desfibrilador antes de los 35 años?	Yes Sí	No

BONE AND JOINT QUESTIONS - PREGUNTAS SOBRE LOS HUESOS Y LAS ARTICULACIONES			
14	Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game? *¿Alguna vez sufrió una fractura por estrés o una lesión en un hueso, músculo, ligamento, articu- lación o tendón que le hizo faltar a una práctica o juego?*	Yes Sí	No
15	Do you have a bone, muscle, ligament, or joint injury that bothers you? *¿Sufre alguna lesión ósea, muscular, de los ligamentos o de las articulaciones que le causa molestia?*	Yes Sí	No

OTHER MEDICAL QUESTIONS ABOUT THE ATHLETE/PATIENT – OTRAS PREGUNTAS SOBRE CONDICIONES MÉDICAS DEL ATLETA/PACIENTE			
16	Do you cough, wheeze, or have difficulty breathing during or after exercise? *¿Tose, sibila o experimenta alguna dificultad para respirar durante o después de hacer ejercicio?*	Yes Sí	No
17	Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ? *¿Le falta un riñón, un ojo, un testículo (en el caso de los hombres), el bazo o cualquier otro órgano?*	Yes Sí	No
18	Do you have groin or testicle pain or a painful bulge or hernia in the groin area? *¿Sufre dolor en la ingle o en los testículos, o tiene alguna protuberancia o hernia dolorosa en la zona inguinal?*	Yes Sí	No
19	Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant Staphylococcus aureus(MRSA)? *¿Padece erupciones cutáneas recurrentes o que aparecen y desaparecen, incluyendo el herpes o Staphylococcus aureus resistente a la meticilina (MRSA)?*	Yes Sí	No
20	Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems? *¿Alguna vez sufrió un traumatismo craneoence- fálico o una lesión en la cabeza que le causó confusión, un dolor de cabeza prolongado o problemas de memoria?*	Yes Sí	No
21	Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling? *¿Alguna vez sintió adormecimiento, hormigueo, debilidad en los brazos o piernas, o fue incapaz de mover los brazos o las piernas después de sufrir un golpe o una caída?*	Yes Sí	No
22	Have you ever become ill while exercising in the heat? *¿Alguna vez se enfermó al realizar ejercicio cuando hacía calor?*	Yes Sí	No
23	Do you or does someone in your family have sickle cell trait or disease? *¿Usted o algún miembro de su familia tiene el rasgo drepanocítico o padece una enfermedad drepanocítica?*	Yes Sí	No
24	Have you ever had or do you have any prob- lems with your eyes or vision? *¿Alguna vez tuvo o tiene algún problema con sus ojos o su visión?*	Yes Sí	No
25	Do you worry about your weight? *¿Le preocupa su peso?*	Yes Sí	No
26	Are you trying to or has anyone recommended that you gain or lose weight? *¿Está tratando de bajar o subir de peso, o alguien le recomendó que baje o suba de peso?*	Yes Sí	No
27	Are you on a special diet or do you avoid certain types of foods or food groups? *¿Sigue alguna dieta especial o evita ciertos tipos o grupos de alimentos?*	Yes Sí	No
28	Have you ever had an eating disorder? *¿Alguna vez sufrió un desorden alimenticio?*	Yes Sí	No

FEMALES ONLY - ÚNICAMENTE MUJERES			
29	Have you ever had a menstrual period? *¿Ha tenido al menos un periodo menstrual?*	Yes Sí	No
30	How old were you when you had your first menstrual period? *¿A los cuántos años tuvo su primer periodo menstrual?*	Yes Sí	No
31	When was your most recent menstrual period? *¿Cuándo fue su periodo menstrual más reciente?*	Yes Sí	No
32	How many periods have you had in the past 12 months? *¿Cuántos periodos menstruales ha tenido en los últimos 12 meses?*	Yes Sí	No

Explanation for yes answers above
Explicación para las preguntas en las que contestó "Sí"

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Adapted – American Academy of Pediatrics Pre-participation Evaluation History Form 2019

Staying Healthy Assessment

9-11 Years

Child's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date	In Child/Day Care □ Yes ☐ No
Person Completing Form	☐ Parent ☐ Relative ☐ Friend ☐Guardian ☐ Other (specify)			Need Help with Form □ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? □ Yes ☐ No

					Clinic Use Only:
1	Does your child drink or eat 3 servings of calcium-rich foods daily, such as formula, breast milk, cheese, yogurt, soy milk, or	Yes	No	Skip	*Nutrition*
2	Does your child eat fruits and vegetables at least 2 times per day?	Yes	No	Skip	
3	Does your child eat high-fat foods, such as fried foods, chips, ice cream, or pizza more than once per week?	No	Yes	Skip	
4	Does your child drink more than one cup (4 – 6 oz.) of juice per	No	Yes	Skip	
5	Does your child drink soda, juice drinks, sports drinks, energy drinks, or other sweetened drinks more than once	No	Yes	Skip	
6	Does your child exercise or play sports most days of the week?	Yes	No	Skip	*Physical Activity*
7	Are you concerned about your child's weight?	No	Yes	Skip	
8	Does your child watch TV or play video games less than 2 hours a day?	Yes	No	Skip	
9	Does your home have a working smoke detector?	Yes	No	Skip	*Safety*
10	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	Skip	
11	Does your child always use a seatbelt in the back seat (or use a booster seat if under 4'9")?	Yes	No	Skip	
12	Does your child spend time near a swimming pool, river, or lake?	No	Yes	Skip	
13	Does your child spend time in a home where a gun is kept?	No	Yes	Skip	
14	Does your child spend time with anyone who carries a gun, knife, or other weapon?	No	Yes	Skip	
15	Does your child always wear a helmet when riding a bike, skateboard, or scooter?	Yes	No	Skip	
16	Has your child ever witnessed or been a victim of abuse or violence?	No	Yes	Skip	
17	Has your child hit or been hit by someone in the past year?	No	Yes	Skip	
18	Has your child ever been bullied or felt unsafe at school or in your neighborhood (or been cyber-bullied)?	No	Yes	Skip	
19	Does your child brush and floss her/his teeth daily?	Yes	No	Skip	*Dental Health*
20	Does your child often seem sad or depressed?	No	Yes	Skip	*Mental Health*
21	Does your child spend time with anyone who smokes?	No	Yes	Skip	*Drug, Alcohol & Tobacco Exposure*
22	Has your child ever smoked cigarettes or chewed tobacco?	No	Yes	Skip	

23	Are you concerned your child may be using drugs or sniffing substances, such as glue, to get high?	No	Yes	Skip	
24	Are you concerned that your child may be drinking alcohol, such as beer, wine, wine coolers, or liquor?	No	Yes	Skip	
25	Does your child have friends or family members who have a problem with alcohol or other drugs?	No	Yes	Skip	
26	Has your child started dating or “going out” with boyfriends or girlfriends?	No	Yes	Skip	*Sexual I s sues*
27	Do you think your child might be sexually active?	No	Yes	Skip	
28	Does your child have any family members who suffer from depression, anxiety, PTSD or other mental health	No	Yes	Skip	*Home Environment*
29	(For parents) Does a partner, or anyone at home, hurt, hit or threaten you?	No	Yes	Skip	
30	Has your child ever been away from either parent due to parental illness, separation, foster care, parental incarceration or other reasons?	No	Yes	Skip	
31	Has anything really scary or upsetting happened to your child or anyone in your family?	No	Yes	Skip	
32	In the last year, have you been worried that your food would run out before you were able to get more?	No	Yes	Skip	*Other Questions*
33	In the last year, have you been worried that you would need to move out of a place you were staying due to inability to afford the rent, or for other reasons?	No	Yes	Skip	
34	Do you have any other questions or concerns about your baby’s health, development, or behavior?	No	Yes	Skip	

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
□ Nutrition	☐	☐	☐	☐	
□ Physical Activity	☐	☐	☐	☐	
□ Safety	☐	☐	☐	☐	
□ Dental Health	☐	☐	☐	☐	
□ Mental Health	☐	☐	☐	☐	
□ Drug, Alcohol & Tobacco Exposure	☐	☐	☐	☐	
□ Sexual Issues	☐	☐	☐	☐	□ **Patient Declined the SHA**
□ Home Environment	☐	☐	☐	☐	
PCP’s Signature:	Print Name:				Date:
SHA ANNUAL REVIEW					
PCP’s Signature:	Print Name:				Date:
PCP’s Signature:	Print Name:				Date:

GARDNER
Packard Children's Health Center

Family Needs Screening[1,2]

Our goal at Gardner Packard Children's Health Center is to provide the best possible care for your child and family. We would like to make sure you know resources available to you for your family's needs. Please answer both questions and give to your child's doctor at the beginning of the visit. Thank You!

1. Which of these would you like help with today? (Check all that apply)

   - ❑ Food
   - ❑ Housing
   - ❑ Living conditions (like mold in your home)
   - ❑ Utilities
   - ❑ Transportation
   - ❑ Tutoring or Homework Help
   - ❑ Childcare or preschool

   - ❑ None of these

2. Which of the concerns above is most important to talk about today?

Adapted from: [1] Centers for Medicare & Medicaid Services (CMS) Accountable Health Communities (AHC) Health Related Social Needs Screening Tool and [2] WE-CARE: Well-child care visit; Evaluation; Community resources; Advocacy; Referral; Education. Modified on 6/12/2018.

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Medical Record Number

Patient Name

Addressograph or Label

TUBERCULOSIS RISK FACTOR ASSESSMENT

Exposure Risk

1. Has a family member or someone your child has been in contact with had tuberculosis disease? ❑ Yes ❑ No
2. Has your child, a family member, or someone your child has been in contact with had a positive TB test or received medications for TB? ❑ Yes ❑ No
3. Was your child born in another country*? ❑ Yes ❑ No
4. Has your child traveled outside of the United States for more than a month? ❑ Yes ❑ No

*Excluding Canada, Australia, New Zealand, or Western and Northern European countries

I attest that the above information is true to the best of my knowledge.

Parent/Guardian Signature: _____Date: _____