18 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 medica-mento, 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 prob- lemas cardíacos?*	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"

Staying Healthy Assessment

Adult

Patient's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date
Person Completing Form *(if patient needs help)*	☐ Family Member ☐ Friend ☐ 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	Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	Nutrition
2	Do you eat fruits and vegetables every day?	Yes	No	Skip	
3	Do you limit the amount of fried food or fast food that you eat?	Yes	No	Skip	
4	Are you easily able to get enough healthy food?	Yes	No	Skip	
5	Do you drink a soda, juice drink, sports or energy drink most days of the week?	No	Yes	Skip	
6	Do you often eat too much or too little food?	No	Yes	Skip	
7	Are you concerned about your weight?	No	Yes	Skip	
8	Do you exercise or spend time doing activities, such as walking, gardening, swimming for ½ hour a day?	Yes	No	Skip	Physical Activity
9	Do you feel safe where you live?	Yes	No	Skip	Safety
10	Have you had any car accidents lately?	No	Yes	Skip	
11	Have you been hit, slapped, kicked, or physically hurt by someone in the last year?	No	Yes	Skip	
12	Do you always wear a seat belt when driving or riding in a car?	Yes	No	Skip	
13	Do you keep a gun in your house or place where you live?	No	Yes	Skip	
14	Do you brush and floss your teeth daily?	Yes	No	Skip	Dental Health
15	Do you often feel sad, hopeless, angry, or worried?	No	Yes	Skip	Mental Health
16	Do you often have trouble sleeping?	No	Yes	Skip	
17	Do you smoke or chew tobacco?	No	Yes	Skip	Alcohol, Tobacco, Drug Use
18	Do friends or family members smoke in your house or place where you live?	No	Yes	Skip	

19	In the past year, have you had: ☐ **(men)** 5 or more alcohol drinks in one day? ☐ **(women)** 4 or more alcohol drinks in one day?	No	Yes	Skip	
20	Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight?	No	Yes	Skip	
21	Do you think you or your partner could be pregnant?	No	Yes	Skip	Sexual Issues
22	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	No	Yes	Skip	
23	Have you or your partner(s) had sex without using birth control in the past year?	No	Yes	Skip	
24	Have you or your partner(s) had sex with other people in the past year?	No	Yes	Skip	
25	Have you or your partner(s) had sex without a condom in the past year?	No	Yes	Skip	
26	Have you ever been forced or pressured to have sex?	No	Yes	Skip	
27	Do you have other questions or concerns about your health?	No	Yes	Skip	Other Questions

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered
☐ Nutrition	☐	☐	☐	☐
☐ Physical activity	☐	☐	☐	☐
☐ Safety	☐	☐	☐	☐
☐ Dental Health	☐	☐	☐	☐
☐ Mental Health	☐	☐	☐	☐
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐
☐ Sexual Issues	☐	☐	☐	☐

Comments:

☐ **Patient Declined the SHA**

PCP's Signature:	Print Name:	Date:

SHA ANNUAL REVIEW

PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
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.

GARDNER
Packard Children's Health Center

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 week*? ❑ 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: _____