MERIDELL ACHIEVEMENT CENTER
MEDICAL HISTORY

Patient Label Here

Patient Name: _____ DOB: _____

IDENTIFYING INFORMATION:

Age _____ Hair color _____ Race _____ Height _____
Sex _____ Eye color _____ Tattoos _____ Weight _____

ALLERGIES/TYPE OF REACTION: ☐ EPI-PEN Required/Bringing ☐ **NO KNOWN ALLERGIES**

Drugs (List/Reaction) _____
Foods (List/Reaction) _____
Other (List/Reaction) _____

IMMUNIZATIONS HISTORY: ***(PLEASE PROVIDE RECORDS)***

Patients not current with their immunizations cannot be accepted for admission. Please request to speak to the Admission's Nurse prior to admission date should you have any questions regarding immunizations.

☐ Immunizations current
☐ Due for _____
☐ HPV, completed or next due _____
☐ Recent flu vaccine, date _____
☐ Recent *Tamiflu,* date _____
☐ No immunizations since _____
☐ Has had a TB screen in last 3 months. When _____
☐ Received BCG (TB) Vaccine _____
When _____, Where _____

Immunizations are not provided at Meridell

MEDICAL / HEALTH, PAST OR CURRENT ☐ **NO HISTORY OF MEDICAL ISSUES**

☐ Nasal allergies _____
☐ Sinus infections _____
☐ Respiratory infections _____
☐ Asthma ☐ Inhaler required
☐ Allergy shots _____
☐ Tonsillitis _____
☐ Nose bleeds _____
☐ Persistent cough _____
☐ Frequent ear infection
☐ Required tubes in ears _____
☐ Frequent Strep _____
☐ Urinary Tract Infections _____
☐ Frequent upset stomach _____
☐ Chronic constipation _____
☐ Encopresis (soiling self) _____
☐ Enuresis (wetting self)
☐ Relevant weight change ☐↑ ☐↓# _____
☐ Eating Disorders _____
☐ Diabetes, type _____
☐ Frequent headaches ☐ Migraines
☐ Positive Tuberculosis screen _____
☐ MRSA, when? _____
☐ Thyroid issues _____
☐ Frequent / Chronic fatigue
☐ Rapid or ☐ slow pulse _____
☐ High or ☐ low blood pressure
☐ Murmurs _____
☐ Other Heart condition _____
☐ Broken bones _____
☐ Muscle ☐ joint or ☐ bone pain
☐ Hepatitis _____
☐ Seizures _____
☐ Other _____

Please explain any checked issues: _____

History of Major Accidents or Injuries: ☐ No ☐ Yes, age/type: _____

History of Surgical Procedures: ☐ No ☐ Yes, age/type: _____

MEDICAL/PHYSICAL ISSUES CREATING BARRIERS TO LEARNING: ☐ **NO OTHER ISSUES**

Describe: _____

CONDITIONS REQUIRING ONGOING MEDICAL OVERSITE: ☐ **NO OTHER ISSUES**

Describe: _____

Pre-Admission Protocols for Pre-Existing Medical Conditions ☐ **NOT APPLICABLE**

☐ Patient's specialist has been informed of patient's upcoming admission to Meridell.
☐ Specialist agrees to be available for consults on treatment issues, protocols, orders or insulin adjustments.
☐ Release of Information signed with current specialist for Meridell to have access to needed information, specifically current medications, physician's orders, treatment plans and verbal exchange of information.
☐ Specialist has provided a written outline of medication, allergy shot protocols, regiment of scheduled and PRN Blood Glucose testing times, sliding scale instructions & dietary guidelines for Meridell to review prior to admit.
☐ All required medications and supplies for medical condition will be provided and brought in at the time of admission.

Specialist Name	Phone Numbers	Other	Condition

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NEUROLOGICAL: ☐ **NO ISSUES**

☐ History of head injuries: Age at the time(s) _____
☐ Loss of consciousness, how long:_____
☐ Patient received / required medical interventions /testing /evaluations due to the injury?_____
☐ Behavioral or developmental changes noticed after the injury?_____
☐ Other traumatic injuries:_____
☐ Previous Quantitative (Q)EEG: Date:_____ Results:_____
☐ Previous Neurological Exam: Date:_____ Results:_____
☐ History of Neurological issues:
- ☐ Seizures, Type:_____Age at onset:_____ Date of last seizure:_____
- ☐ Tremors ☐ Numbness ☐ Tingling ☐ Fainting ☐ Dizziness ☐ Other _____
- ☐ TICs, Describe:_____

HEARING DIFFICULTIES HISTORY: ☐ **NO CURRENT AUDITORY ISSUES**

☐ Pain / ringing / discharge / excessive wax
☐ Has some hearing impairments/loss
☐ Received Speech / Language Services (age) _____
☐ Wears hearing aids / prosthesis_____

HISTORY OF SLEEP PATTERNS: **Average Number of Hours Slept Without Sleep Aids** _____

☐ Sleeps through the night	☐ Difficulty falling asleep	☐ Nightmares or ☐ terrors
☐ Early morning riser, w/out prompts	☐ Frequent awakening	☐ Bed wetting (enuresis)
☐ Difficult to get up in morning	☐ Snores or ☐ sleep apnea	☐ Wears pull-ups
☐ Daytime drowsiness	☐ Sleep walking or ☐ talking	☐ Needs prompts to empty bladder
☐ Recent changes in sleep patterns	☐ Roams around at night	☐ Uses sleep aids_____

ACTIVITIES of DAILY LIVING: ☐ **INDEPENDENT, NO ASSISTANCE NEEDED**

☐ Needs prompts or ☐ supervision for toileting /hygiene
☐ Needs prompts or ☐ supervision for dressing
☐ Needs prompts or ☐ supervision for bathing /shampooing
☐ Needs prompts or ☐ supervision for oral hygiene

Describe types of assistance patient requires:_____

_____

SEXUAL ACTIVITY HISTORY: ☐ **SEXUALLY ACTIVE** ☐ **NOT SEXUALLY ACTIVE**

☐ Recently tested for STDs_____
☐ History of STDs:_____

MENSTRUAL HISTORY: ☐ **NOT APPLICABLE due to** ☐ **Gender** ☐ **Age**

☐ Educated regarding menses
☐ Age at onset of menses_____
☐ Allowed to use Tampons
☐ Use of Birth Control Pill for _____
☐ Other methods of birth control_____
☐ Date of last GYN exam _____
☐ Previous Pelvic Exam/Pap Smear _____
☐ Pelvic Inflammatory Disease _____
☐ Other Gynecological issues _____
☐ Pregnancies/Abortions_____

DENTAL

Can provide dental insurance information Yes / No	Dentist Name	Address	Phone #	Fax #	Last Check-up

TX Dept. of Family & Protective Services standard **748.1225(b)** requires us to request documentation (of the most recent dental exam occurring in the past 12 months) from the family or from the patient's dentist.

☐ I will provide documentation of a dental exam from the last 12 months.
☐ I prefer our dentist not be contacted to obtain records of dental history.
☐ I wish to defer any routine dental appointments until after discharge, unless issues arise that are acute. Orthodontic appointments are typically suspended during treatment, unless families make arrangements to find a provider and provide transportation. Emergency dental interventions are obtained locally.

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Patient Label Here

Patient Name: _____

MEDICATION HISTORY:

Please check all medications that your child has taken in the past:

(+) Positive Results (-) Negative Results (?) Questionable or Unknown Results	Results	Reason for Stopping if Discontinued
ANTI-DEPRESSANTS		
Adapin (Doxepin)		
Anafranil (Clomipramine)		
Celexa (Citalopram)		
Cymbalta (Duloxetine)		
Desyrel (Trazodone)		
Effexor (Venlafaxine HCl)		
Effexor XR		
Elavil (Amitryptyline)		
Lexapro (Escitalopram)		
Luvox (Fluvoxamine)		
Pamelor (Nortriptyline)		
Paxil (Paroxetine)		
Pristiq (Desvenlafaxine)		
Prozac (Fluoxetine)		
Remeron (Mirtazapine)		
Serzone (Nefazodone)		
Sinequan (Doxepin)		
Tofranil (Imipramine)		
Vivactil (Protriptyline)		
Wellbutrin (Buproprion)		
Wellbutrin SR		
Wellbutrin XL		
Zoloft (Sertraline)		
ANTIHISTAMINES		
Benadryl (Diphenhydramine)		
Vistaril (Hydroxyzine)		
ANTI-HYPERTENSIVES		
Clonidine (Catapres)		
Inderal (Propanolol)		
Intuniv (Guanfacine LA)		
Tenex (Guanfacine)		
STIMULANTS		
Adderall		
Adderall XR		
Concerta (Methylphenidate) ER		
Daytrana (Methylphenidate patch)		
Dexedrine		
Dexedrine Spansule		
Focalin (dexmethylphenidate)		
Metadate CD		
Provigil (Modafinil)		
Ritalin (Methylphenidate)		
Ritalin LA (Methylphenidate LA)		
Ritalin SR (Methylphenidate SR)		
Vyvanse (Lisdexamfetamine)		

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(+) Positive Results (-) Negative Results (?) Questionable or Unknown Results	Results	Reason for Stopping if Discontinued
MOOD STABILIZERS		
Depakene (Valproate Na)		
Depakote (Divalproic Acid)		
Depakote ER		
Lithium (Eskalith, Lithobid)		
Tegretol (Carbamazepine)		
Topamax (Topirarmate)		
Trileptal (Oxcarbazepine)		
ANTI CONVULSANTS		
Carbatrol (Carbamazepine)		
Equetro (Carbamazepine)		
Gabitril (Tiagabine)		
Keppra (Levetiracetam)		
Lamictal (Lamotrigine)		
Zonegran (Zonisamide)		
ANTI-PSYCHOTICS		
Abilify (Aripiprazole)		
Clozaril (Clozapine)		
Fanapt (Iloperidone)		
Geodon (Ziprasidone)		
Haldol (Haloperidol)		
Invega ER (Paliperidone)		
Mellaril (Thioridazine)		
Neurontin (Gabapentin)		
Orap (Pimozide)		
Prolixin (Fluphenazine)		
Risperdal (Risperidone)		
Saphris (Asenapine)		
Seroquel (Quetiapine)		
Thorazine (Chlorpromazine)		
Zyprexa (Olanzapine)		
Zyprexa Zydis		
BENZODIAZEPINES		
Ativan (Lorazepam)		
Klonopin (Clonazepam)		
Valium (Diazepam)		
Xanax (Alprazolam)		
SLEEP AIDES		
Ambien (Zoldipem)		
Lunesta (Eszopiclone)		
Restoril (Temazepam)		
Sonata (Zaleplon)		
OTHER		
Amantadine (Symmetrel)		
Buspar (Buspirone HCl)		
Cogentin (Benztropine)		
Strattera (Atomoxetine)		

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Patient Name: _____

History of Medication Noncompliance / Deceit /Abuse **NO** ☐ **YES** ☐ Describe: _____

Please list all current medications including prescription and over-the-counter medications used routinely:

If you do not know the current medication information due to recent hospitalization, please ensure all current medication information arrives with patient. <u>If you are coming with the patient, bring all medications and medication information in with you when you first enter the building.</u> Please send or fax medication discharge information or prescriptions from discharging facility as soon as you receive them.

Medications	Dosage @ ea. time	Route	Times	Rationale	Conditions Instructions
Ex. Risperdal	0.5mg	Oral	0800 & 1400	Mood Stabilization	Take Before Breakfast

Medications for any <u>medical</u> diagnosis not related to psychiatric treatment, are to be provided by the family or guardian. No expired medications will be accepted, family provided medications expiring while in treatment will not be administered and will be discarded.

Send a minimum of a 1 month supply of all <u>non-psych medications</u> you want continued or plan to provide as available. All medications (psych and non-psych) should be delivered in the original container in which they were dispensed or purchased. All medications, including Epi-Pens, must be current and non-expired.

Any additional needed supplies for pre-existing medical conditions or specific hygiene issues (Pull-ups) are to be provided for by the family or guardians.

FAMILY MEDICAL HISTORY:

Include Patient's Biological Parents, Grandparents, Aunts, Uncles Siblings, and 1st Cousins

	Mother's Side Relationship to Patient *or* ☐ Family History Unknown	**Father's Side Relationship to Patient *or* ☐ Family History Unknown**
Diabetes		
Hypertension		
Heart Disease		
Cancer		
Other Medical		
Other Medical		

Completed By: _____ _____ _____

Date Relationship to Patient

Admitting Nurse Reviewing Patient History _____

Signature Date

Additional Nursing Comments/Information/Clarification _____