Medical Passport

A convenient medical history

Please Read

Because a patient's medical history can influence treatment, personal medical records are important. In case of emergency, the answers to questions such as "Does the patient have any allergies?" or "When was the patient's last tetanus shot?" can be vitally helpful. Keep this information handy, and update it regularly.

Warning! The information in this document is for you to provide to doctors or medical personnel attending the individual to whom it pertains. It is being made available from records deemed confidentiality and therefore protected by state law. State law prohibits you from making any further disclosure of any information contained in these records without the specific consent of the person to whom it pertains and that persons's legal guardian. Unauthorized disclosure of information contained in this document may make you liable for substantial damages in a court of law.

INDIANA DEPARTMENT OF CHILD SERVICES

State of Indiana

Department of Child Services
402 W. Washington Street, Room W392–MS03
Indianapolis, Indiana 46207-7083

www.in.gov/dcs

Confidential Medical Records

NAME _____
Last First Middle

MEDICAID # _____

Date of Birth _____ Sex _____
Male/Female

Ethnicity _____

Native Language _____

Mother's Name _____
Last First Middle

Father's Name _____
Last First Middle

MEDI-ALERT
(serious medical condition such as sickle-cell disease, asthma, diabetes, epilepsy, cardiac problems, previous positive TB skin test)

_____
_____
_____
_____
_____
_____

ALLERGIES
(bee stings, medications, foods)

_____
_____
_____
_____
_____
_____

ADVERSE REACTIONS
(rash, respiratory distress)

_____
_____
_____
_____
_____

DEVICES/EQUIPMENT
(glasses, hearing aid, wheelchair, etc.)

_____

_____

_____

_____

SPECIAL DIET

_____

_____

_____

_____

Child's Medical History

HOSPITAL OF BIRTH

_____
Name of Hospital

_____
City State Zip

CHILD'S BIRTH WEIGHT

lbs. and ozs. _____

PROBLEMS WITH PREGNANCY OR DELIVERY

_____

_____

_____

_____

_____

_____

WAS CHILD IN SPECIAL CARE NURSERY?
(Reason for using special care nursery, length of stay, etc.)

_____

_____

_____

_____

_____

_____

_____

CHRONIC HEALTH PROBLEMS

- ☐ Ear Infection
- ☐ Eczema
- ☐ Asthma
- ☐ Seizures
- ☐ Developmental Delay
- ☐ Urinary Problems
- ☐ Bone/Joint Problems
- ☐ Heart
- ☐ Diabetes
- ☐ Other

Explain: _____

_____

_____

_____

TRAUMA

(e.g., fractures, head injuries, burns)

_____

_____

_____

_____

CHILDHOOD ILLNESSES

- ☐ Chickenpox
- ☐ Infectious Mononucleosis
- ☐ Meningitis
- ☐ Roseola
- ☐ German Measles (Rubella)
- ☐ Measles (Rubeola)
- ☐ Mumps
- ☐ Scarlet Fever
- ☐ Other _____

_____

_____

SENSORY PROBLEMS

- ☐ Vision _____ Date of Onset
- ☐ Hearing _____ Date of Onset
- ☐ Other _____ Date of Onset

Explain: _____

_____

_____

_____

_____

ADDICTIONS:

- ☐ Cigarettes
- ☐ Drug Use
- ☐ Alcohol
- ☐ Other _____

_____

_____

_____

SEXUAL HISTORY

Sexually Active? ☐ Yes ☐ No

Prior History of Sexual Abuse? ☐ Yes ☐ No

Currently using Birth Control? ☐ Yes ☐ No

Method Used: _____

For Females:

Age at onset of menses: _____

Pregnancies? ☐ Yes ☐ No

Age and number of live births: _____

HISTORY OF ABUSE?

Physical ☐ Yes ☐ No **Neglect** ☐ Yes ☐ No

Brief Description: _____

BIOLOGICAL FAMILY HISTORY

Maternal History

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Substance Abuse
- ☐ Kidney Problems
- ☐ Asthma
- ☐ Epilepsy, Seizures
- ☐ Birth Defects
- ☐ Deafness
- ☐ Death Under 50 Yrs.
- ☐ Heart Attack Under 60 Yrs.
- ☐ Positive TB Skin Test
- ☐ Stroke
- ☐ Stomach/Intestinal
- ☐ Mental Retardation
- ☐ Psychiatric Problems
- ☐ Blood Disease:
- ☐ (a) Anemia ☐(b) Sickle Cell
- ☐ Other

_____

_____

_____

_____

_____

_____

_____

BIOLOGICAL FAMILY HISTORY

Paternal History

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Substance Abuse
- ☐ Kidney Problems
- ☐ Asthma
- ☐ Epilepsy, Seizures
- ☐ Birth Defects
- ☐ Deafness
- ☐ Death Under 50 Yrs.
- ☐ Heart Attack Under 60 Yrs.
- ☐ Positive TB Skin Test
- ☐ Stroke
- ☐ Stomach/Intestinal
- ☐ Mental Retardation
- ☐ Psychiatric Problems
- ☐ Blood Disease:
- ☐ (a) Anemia ☐(b) Sickle Cell
- ☐ Other

_____

_____

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_____

Recommendations For Preventive Pediatric and Adolescent Health Care for Children in Foster or Residential Care

Each child is unique. These recommendations are designed for children in foster or residential care. Appropriate guidance regarding issues such as diet, safety, physical fitness, and adolescent risk factors should be an integral part of each visit. Children with more serious developmental, psychosocial, and chronic disease issues require more frequent counseling and treatment visits than recommended by these guidelines.

1. Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits, including family care coordination home visits.
2. Newborns discharged in less than 48 hours after delivery may require extra follow-up visits.

SENSORY SCREENING

3. If the patient is uncooperative, rescreen within six months.
4. All infants in Indiana are required to receive hearing screening at birth. If they fail the hearing screen or have other risk factors for hearing loss, hearing should be screened yearly.

DEVELOPMENTAL SCREENING

5. Developmental screening should be done at initial visit by a standardized developmental test such as DDSTII or parent developmental questionnaire such as PDQ, and by history and appropriate physical examination, if developmental delay is suspected.

GENERAL PROCEDURES

6. These may be modified depending upon entry point into schedule and individual need.
7. Metabolic screening including Sickle Cell screening. Indiana State Law states that it should be done prior to discharge following delivery. However, it must be repeated if screening is done less than 48 hours after birth.
8. Follow the current immunization schedule.
9. Lead screening should be performed at 9, 12 and 24 months on all Medicaid enrolled or high risk children, as well as yearly if there are other risk factors present.
10. All menstruating adolescents should have a hemoglobin/hematocrit screen.
11. Conduct dipstick urinalysis for leukocytes for male and female adolescents.
12. An oral health risk assessment should be performed on all patients beginning at 6 months of age. Patients who have been determined to be at risk of development of dental caries should receive a professional dental examination 6 months after the first tooth erupts or by 1 year of age, whichever comes first.

AT RISK PROCEDURES

13. TB testing per AAP statement "Screening for Tuberculosis in Infants and Children" (1994). Testing should be done upon recognition of high risk factors. If results are negative but high risk situation continues, testing should be repeated on an annual basis.

    Children in foster or residential care are considered at high risk and must be tested annually.

    When the need for TB skin testing is indicated, the Mantoux PPD (syringe measured dose) should be used. May be given simultaneously with MMR or give MMR when Mantoux is read.

14. Cholesterol screening for high risk patients per AAP statement on "Cholesterol in Childhood" (Pediatrics. 1998, Jan; 101 (1 Pt 1): 141-7). If family history cannot be ascertained and other risk factors are present, screening should be at the discretion of the physician.

15. At risk adolescents should be screened one time for Sickle Cell if Newborn screening results are unknown or unavailable.

16. All sexually active patients should be screened for sexually transmitted diseases (STDs). Confidential pregnancy testing and HIV testing should also be encouraged for all sexually active patients especially those with other diagnosed STDs. Evidence of sexual abuse of a minor is reportable under State Law. The offense increases in severity the younger the minor and the greater the age difference between the minor and the perpetrator.

17. All sexually active females should have a pelvic examination. A pelvic examination and routine pap smear should be offered as part of preventive health maintenance between the ages of 18 and 21 years.

	Middle Childhood								Adolescence							
Age	**5 yr**	**6 yr**	**7 yr**	**8 yr**	**9 yr**	**10 yr**	**11 yr**	**12 yr**	**13 yr**	**14 yr**	**15 yr**	**16 yr**	**17 yr**	**18 yr**	**19 yr**	**20 yr**
Height, Weight / BMI																
Blood Pressure																
Vision																
Hearing [4]																
Developmental/Behavioral Screening [5]																
Hereditary/Metabolic Screening [7]																
Lead Screening [9]																
Hematocrit or Hemoglobin [10]																
Urinalysis [11]																
Professional Dental Exam [12]																
Tuberculin Skin Test [13]																
Cholesterol Screening [14]																
Sickle Cell Screening [15]																
GC, Chlamydia, Syphilis, HPV, HIV [16]																
Pelvic Exam and PAP Smear [17]																
Immunization — See Current Immunization Schedule [8]																
Screener																

Physical Examinations

	Infancy								Early Childhood				
Age	**Newborn**	**2-4 days**	**By 1 Mo**	**2 mo**	**4 mo**	**6 mo**	**9 mo**	**12 mo**	**15 mo**	**18 mo**	**24 mo**	**3 yr**	**4 yr**
Height, Weight / BMI after 24 months													
Head Circumference													
Blood Pressure													
Vision													
Hearing (include NB screen) [4]													
Developmental/Behavioral Screening [5]													
Hereditary/Metabolic Screening [7]													
Lead Screening [9]													
Hematocrit or Hemoglobin													
Dental/Sealant Evaluation													
Professional Dental Exam [12]													
Mantoux Tuberculin Skin Test [13]													
Cholesterol Screening [14]													
Immunization — See Current Immunization Schedule [8]													
Screener													

Key: **White Box** — Recommended at this age **Dark Shaded Box** — NOT recommended at this age **Light Shaded Box** — To be performed on patients at RISK

Contraindications: _____

_____

Vaccine	Date	Initial	Date	Initial	Date	Initial	Date	Initial	Date	Initial
Influenza, inactivated										
Influenza, LAIV (FluMist)										
IPV										
OPV										
MMR										
Mening. conj. vaccine (Menactra)										
Mening. polysacc. vaccine (Menomune)										
Pneumo. conj. vaccine (Prevnar)										
Pneumo polysacc. vaccine (Pneumovax)										
Varicella										
Hep A- Child/Adolescent										
Hep A - Adult										
Other (Specify)										

Immunizations

Contraindications: _____

Vaccine	Date	Initial	Date	Initial	Date	Initial	Date	Initial	Date	Initial
DTaP/DTP										
DT (Pediatric)										
Td										
TdaP (Boostrix or Adacel)										
DTaP-Hib (TriHIBit)										
DTap-Hep B-IPV (Pediarix)										
Hep B Pediatric/Adol										
Hep B 2 dose Adol (Recombivax HB)										
Hep B Adult										
Hib (ActHIB)										
Hib (HibTITER)										
Hib (Pedvax HIB)										
Hep B - Hib (COMVAX)										
Hep A - Hep B (Twinrix)										

Medical Problem	Date Identified	Date Resolved	Doctor	Address	Telephone

Identified Medical Problems

(To be completed by health providers only)

Medical Problem	Date Identified	Date Resolved	Doctor	Address	Telephone

Long Term Medications

Drug	Used For	Dose	Date Began	Date End	Drug	Used For	Dose	Date Began	Date End

Hospitalizations/Medications

Hospitalization / Surgery	Date	Diagnosis	Hospitalization / Surgery	Date	Diagnosis

Refraction

Add for near: Add for intermediate:

Date	Eye	Sphere	Cylinder	Axis	Prism

Add for near: Add for intermediate:

Date	Eye	Sphere	Cylinder	Axis	Prism

Add for near: Add for intermediate:

Date	Eye	Sphere	Cylinder	Axis	Prism

Add for near: Add for intermediate:

Date	Eye	Sphere	Cylinder	Axis	Prism

Add for near: Add for intermediate:

Date	Eye	Sphere	Cylinder	Axis	Prism

Add for near: Add for intermediate:

Date	Eye	Sphere	Cylinder	Axis	Prism

Add for near: Add for intermediate:

Date	Eye	Sphere	Cylinder	Axis	Prism

Add for near: Add for intermediate:

Date	Eye	Sphere	Cylinder	Axis	Prism

Vision

Left Eye (OS)	**At Age 3 Years**	**At Age 6 Years**	**Date_____**	**Date_____**	**Date_____**	**Date_____**	**Date_____**
Near Sighted (myopia)	☐	☐	☐	☐	☐	☐	☐
Far Sighted (hyperopia)	☐	☐	☐	☐	☐	☐	☐
Astigmatism	☐	☐	☐	☐	☐	☐	☐
Crossed eyes (strabismus)	☐	☐	☐	☐	☐	☐	☐
Prism	☐	☐	☐	☐	☐	☐	☐

Other (list): _____

_____

Right Eye (OD)	**At Age 3 Years**	**At Age 6 Years**	**Date_____**	**Date_____**	**Date_____**	**Date_____**	**Date_____**
Near Sighted (myopia)	☐	☐	☐	☐	☐	☐	☐
Far Sighted (hyperopia)	☐	☐	☐	☐	☐	☐	☐
Astigmatism	☐	☐	☐	☐	☐	☐	☐
Crossed eyes (strabismus)	☐	☐	☐	☐	☐	☐	☐
Prism	☐	☐	☐	☐	☐	☐	☐

Other (list): _____

_____

Dental Problem	Date Identified	Date Resolved	Dentist	Address	Telephone

Hearing

Left Ear	Condition	Right Ear	Condition
At Age 18 Months		At Age 18 Months	
At Age 5 Years		At Age 5 Years	
Date		Date	
Date		Date	
Date		Date	
Date		Date	
Date		Date	
Date		Date	
Date		Date	
Date		Date	
Date		Date	
Date		Date	
Date		Date	
Date		Date	
Date		Date	
Date		Date	

Developmental Problem/Screening (Date all entries)

Interventions / Referrals (Date all entries)

Developmental Problems / Screening

☐ **Appropriate Development for Age** ☐ **Possible Delay** ☐ **Confirmed Delay**

Developmental Problem/Screening (Date all entries)

Interventions / Referrals (Date all entries)

Treatments

Begin Date	End Date	Type of Treatment	Provider	Provider Telephone Number

Mental Health Screen/Assessment

Mental Health Screen

Date	Completed By	Results

Assessments

Date	Completed By	Diagnosis/Needs	Strengths	Recommendations (Type and Intensity of Care

Referrals

Problem	Date Identified	Date Resolved	Doctor / Provider	Address	Telephone

Previous Health Providers

Date	Name / Address	Telephone Number

Educational Problems

Educational History

Grade	Year	Name of School	Comments

Date Began	Date Ended	Type of Placement	Social Worker Family Case Manager	Supervisor	Outcome

Placement History

(Note Foster Care, Residential Placements, Return to Parents, etc.)

Date Began	Date Ended	Type of Placement	Social Worker Family Case Manager	Supervisor	Outcome

Additional Notes or Comments

(Date all entries)

Use this handy pocket for Health Care Cards.

INDIANA
DEPARTMENT OF
CHILD
SERVICES

R/3-13