SCREENING RECORD CHMPC

Children's Hospital Medical Practice Corporation

Name
Date of Birth
Chart No.

18 Month

Date_____ Time _____
Actual Age_____ Weight _____lb _____ oz. Height _____in. Temp _____ Pulse _____
Resp _____ Head Circ _____ Pain Score (0 – 5) _____
❑ Environmental Screen ❑ Lead Risk Assessment ❑ Growth chart plotted
Nutrition: ❑ Breast ❑ Whole Milk ❑ Solids ❑ Vitamins ❑ Fluoride
Adverse Reactions (drug allergies): ❑ Yes* _____ ❑ No *If yes, also list on Patient Problem Summary in front of chart.
❑ Parent section reviewed? ❑ Parent's concerns addressed
❑ Immunizations current (copy in chart) ❑ Off Schedule ❑ Parental Refusal Explain _____
Problems: _____

Current Medications: ❑None or list medications below.

Name	Dose	Frequency

Nurse's Signature
X

Physical: Check (☑) if normal. Circle if abnormal and describe.
❑ General Appearance
❑ Head/Face/Neck
❑ Eyes
❑ ENMT
❑ Respiratory
❑ Chest
❑ CV
❑ Abdomen
❑ Genitalia
❑ Skin
❑ Lymph nodes
❑ Extremities ❑ Hips
❑ Musculoskeletal
❑ Back
❑ Neuro

Anticipatory Guidance: ❑ Home Safety ❑ Car Safety ❑ Immunization Information
❑ Nutrition ❑ Medication Education (if applicable)

Assessment: _____

Plan: ❑ Hep A ❑ Flu ❑ Hgb or CBC (If necessary _____ value) ❑ Counseled
❑ Hearing Subjective: Pass _____ Fail _____ ❑ Vision Subjective: Pass _____ Fail _____
❑ Other _____

❑ Interpretive Conference Conducted Return _____
❑ Parent/guardian instructed to keep **Current Medication List** to share with other providers and for emergencies. **INITIALS**_____
❑ Parent/guardian verbalized understanding the **Plan of Care. INITIALS** _____

Physician/Practitioner's Signature **X**	**Date** / /	**Time** AM/PM :

SCREENING RECORD
CHMPC
Children's Hospital Medical Practice Corporation

Name
Date of Birth
Chart No.

PATIENT DATA

Parent Section
18 Month

SECTION TO BE COMPLETED BY PARENT

Personal/Social History
Does your child…
(check appropriate box for each question)

	Yes	No
1. Say 5 – 10 words clearly?	❑	❑
2. Identify a toy by name, e.g. "ball", "car"?	❑	❑
3. Know 4 or more body parts?	❑	❑
4. Show fear, anger, affection, jealousy?	❑	❑
5. Run and climb well?	❑	❑
6. Stack 3 or more blocks?	❑	❑
7. Ride in a safety seat in the rear?	❑	❑
8. Live in a gun-free home?	❑	❑

Are you <u>CONCERNED</u> about your child's…

9. Feedings?	❑	❑
10. Bowel movements?	❑	❑
11. Frequent colds or ear infections?	❑	❑
12. Sleep habits?	❑	❑
13. Excessive whining, fussing or crying?	❑	❑
14. Is your child attending day care?	❑	❑

Parent Section
❑ Mother ❑ Father ❑ Other _____

Do you have smoke alarms in your house?	❑	❑

Environmental Screening
Does your child….

	Yes	No
15 Live in or regularly visit a house built before 1950 (daycare, baby sitter or relative)?	❑	❑
16. Live in or regularly visit a house built before 1978 with recent or ongoing renovation or remodeling (within the past 6 months)?	❑	❑
17. Have a sibling or playmate who now has or did have lead poisoning?	❑	❑
18. Does anyone smoke in the household?	❑	❑
19. Do you have a swimming pool?	❑	❑

History Update

	Yes	No
20. Has there been a change in your child's medical history? _____	❑	❑
21. Has there been a change in your child's family medical history _____	❑	❑
22. Change in household situation? _____	❑	❑

Parent Comments (Please Print)

	Yes	No
23. Do you have any concerns you wish to discuss?	❑	❑

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Signature	Date MM/DD/YY	Time 00:00 AM/PM
X	/ /	: