SCREENING RECORD CHMPC

Children's Hospital Medical Practice Corporation

Name
Date of Birth
Chart No.

10-11 Year Male

Date_____ Time _____
Actual Age_____ Weight _____lb _____ oz. Height _____in. BMI_____
Temp _____ Pulse _____ Resp _____ BP_____ Pain Score (0 – 5)_____
❑ Environmental Screen ❑ Growth chart plotted
Nutrition: ❑ 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: _____
For patients over the age of 6, do they feel safe at home? ❑ Yes ❑ No

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	
❑ Musculoskeletal	
❑ Back	
❑ Neuro	
❑ Psych	❑ Suicide Risk Assessment

Anticipatory Guidance: ❑ School ❑ Nutrition ❑ Tobacco ❑ Alcohol ❑ Drugs ❑ Guns/trigger locks ❑ Initiated PSC-17
❑ Car Safety ❑ Educational handouts ❑ Medication Education (if applicable) ❑ Immunization Information ❑ Sex Education
Assessment: _____

Plan: ❑ Tdap ❑ MCV4 ❑ HPV ❑ Flu ❑ Hgb (If necessary _____ value) ❑ Counseled
❑ Urine Screen (if necessary) ❑ UTO ❑ WNL
❑ Hearing Objective: Pass _____ Fail _____ ❑ Vision Objective: Right _____ Left _____ ❑ Glasses/contacts
❑ Color Perception (if necessary) 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 :

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Chart No.

Parent/Patient Section
10-11 Year Male

SECTION TO BE COMPLETED BY PARENT

Personal/Social History
Are you <u>CONCERNED</u> about your child's…
(check appropriate box for each question)

	Yes	No
1. Overall progress in school?	❑	❑
2. Happiness, self esteem, self confidence?	❑	❑
3. Ability to sit still, listen or participate?	❑	❑
4. School attendance?	❑	❑
5. Physical development?	❑	❑
6. Social development (lack of friends, excessive shyness, withdrawal from family)?	❑	❑
7. Behavioral development (temper outbursts, aggression, violence)?	❑	❑
8. Emotional development (mood changes, anxiety, depression) ?	❑	❑
9. Eating habits, weight loss, loss of energy, sleep habits?	❑	❑
10. Recurrent ear, sinus or throat infections, nosebleeds?	❑	❑
11. Chest pain, shortness of breath, or irregular heartbeat?	❑	❑
12. Frequent colds, cough, wheezing, recurrent bronchitis?	❑	❑
13. Abdominal pain, vomiting, diarrhea, constipation?	❑	❑
14. Urinary control, bed wetting, urinary infections?	❑	❑
15. Joint pain, stiffness, swelling, muscle pain, weakness?	❑	❑
16. Birthmarks, skin rashes, itching, nail or hair problems?	❑	❑
17. Recurrent headaches, dizziness, tics, weak, seizures?	❑	❑
18. Mood changes, sadness, nervous problems?	❑	❑
19. Excessive thirst or hunger, increased urination, weight loss?	❑	❑
20. Paleness, anemia, easy bruising, swollen glands?	❑	❑
21. Milk, food or drug allergies, recurrent infections?	❑	❑

Environmental Screening
Does your child….

	Yes	No
22. Exercise on a regular basis?	❑	❑
23. Use a helmet skating and biking?	❑	❑
24. Use a seat belt, ride in the back?	❑	❑
25. Do you counsel him about avoiding the use of alcohol, tobacco, drugs and inhalants?	❑	❑
26. Are there guns in the house?	❑	❑
27. Does anyone in the household smoke?	❑	❑
28. Do you have a swimming pool?	❑	❑

History Update	Yes	No
29. Has there been a change in your child's medical history?	❑	❑
30. Has there been a change in your child's family medical history	❑	❑
31. Change in household situation?	❑	❑

Parent Comments (Please Print)	Yes	No
❑ Mother ❑ Father ❑ Other		
32. Do you have any concerns you wish to discuss?	❑	❑

Signature
X

Date MM/DD/YY
/ /

Time 00:00 AM/PM
: