SCREENING RECORD CHMPC

Children's Hospital Medical Practice Corporation

Name
Date of Birth
Chart No.

12-15 Year Female

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 ❑ Car Safety ❑ Drugs ❑ Initiated PSC-17 ❑ Safety
❑ Guns/trigger locks ❑ Educational handouts ❑ Medication Education (if applicable) ❑ Sex Education ❑ Exercise
Assessment: Sexually Active Yes ____ No ____ ❑ Contraceptive used Menarche Age_____ LMP_____

Plan: ❑ HPV ❑ Flu ❑ Hgb (If necessary _____value) ❑ Counseled Gravida_____ Para_____
❑ Urine Screen (if necessary) ❑ UTO ❑ WNL
❑ Hearing Objective: Pass _____ Fail _____ ❑ Vision Objective: Right _____ Left _____ ❑Glasses/contacts
❑ Color Perception (if necessary) Pass ___ Fail ____
If sexually active, ❑ Pap Test, screen for: ❑ Chlamydia ❑ Gonorrhea
❑ 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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PATIENT DATA

Parent/Patient Section
12-15 Year Female

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. Menstrual problems?	❑	❑
7. Social development (lack of friends, excessive shyness, withdrawal from family)?	❑	❑
8. Behavioral development (temper outbursts, aggression, violence)?	❑	❑
9. Emotional development (mood changes, anxiety, depression)?	❑	❑
10. Early sexual activity or inappropriate sexual behavior?	❑	❑
11. Eating habits, weight loss, loss of energy, sleep habits?	❑	❑
12. Recurrent ear, sinus or throat infections, nosebleeds?	❑	❑
13. Chest pain, shortness of breath, or irregular heartbeat?	❑	❑
14. Frequent colds, cough, wheezing, recurrent bronchitis?	❑	❑
15. Abdominal pain, vomiting, diarrhea, constipation?	❑	❑
16. Urinary control, bed wetting, urinary infections?	❑	❑
17. Joint pain, stiffness, swelling, muscle pain, weakness?	❑	❑
18. Birthmarks, skin rashes, itching, nail or hair problems?	❑	❑
19. Recurrent headaches, dizziness, tics, weak, seizures?	❑	❑
20. Mood changes, sadness, nervous problems?	❑	❑
21. Excessive thirst or hunger, increased urination, weight loss?	❑	❑
22. Paleness, anemia, easy bruising, swollen glands?	❑	❑
23. Milk, food or drug allergies, recurrent infections?	❑	❑

Environmental Screening
Does your child….

	Yes	No
24. Exercise on a regular basis?	❑	❑
25. Use a helmet skating and biking?	❑	❑
26. Use a seat belt when riding in a car?	❑	❑
27. Do you counsel her about avoiding the use of alcohol, tobacco, drugs and inhalants?	❑	❑
28. Are there guns in the house?	❑	❑
29. Does anyone in the household smoke?	❑	❑

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

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

Signature
X

Date MM/DD/YY
/ /

Time 00:00 AM/PM
: