SCREENING RECORD CHMPC

Children's Hospital Medical Practice Corporation

Name
Date of Birth
Chart No.

16-18 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.
❑ Patient section reviewed? ❑ Patient'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

Physical: Check (☑) if normal. Circle if abnormal and describe.

Nurse's Signature
X

❑ 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: ❑ Exercise ❑ Sex Education ❑ Tobacco ❑ Alcohol ❑ Drugs ❑ Safety ❑ Initiated PSC-17
❑ Driving ❑ Guns/trigger locks ❑ Nutrition ❑ Educational handouts ❑ Medication Education (if applicable)
Assessment: Sexually Active Yes ____ No ____ ❑ Contraceptive used LMP_____ Gravida_____ Para_____

Plan: ❑ 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 ____
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	Date	Time AM/PM
X	/ /	:

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Name
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Patient Section
16-18 Year Female

SECTION TO BE COMPLETED BY PATIENT

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

	Yes	No
1. School/work: (circle) grades, motivation, concentration, completing assignments?	❑	❑
2. Your breasts, menses, pelvic pain, vaginal discharge?	❑	❑
3. Sexual issues: (circle) sexual orientation, sexually transmitted diseases, AIDS/HIV, other?	❑	❑
4. Eating habits, weight loss, loss of energy, sleep habits?	❑	❑
5. Recurrent ear, sinus or throat infections, nosebleeds?	❑	❑
6. Chest pain, shortness of breath, or irregular heartbeat?	❑	❑
7. Frequent colds, cough, wheezing, recurrent bronchitis?	❑	❑
8. Abdominal pain, vomiting, diarrhea, constipation?	❑	❑
9. Urinary control, bed wetting, urinary infections?	❑	❑
10. Joint pain, stiffness, swelling, muscle pain, weakness?	❑	❑
11. Birthmarks, skin rashes, itching, nail or hair problems?	❑	❑
12. Recurrent headaches, dizziness, tics, weak, seizures?	❑	❑
13. Mood changes, sadness, nervous problems?	❑	❑
14. Excessive thirst or hunger, increased urination, weight loss?	❑	❑
15. Paleness, anemia, easy bruising, swollen glands?	❑	❑
16. Milk, food or drug allergies, recurrent infections?	❑	❑

Environmental Screening

	Yes	No
17. Have you had a pelvic examination? Approx. date _____ Pap test _____	❑	❑
18. When was your last menstrual cycle? _____		
19. Are you sexually active now?	❑	❑
If yes, do you always use a condom?	❑	❑
20. Do you use cigarettes, smokeless tobacco?	❑	❑
21. Do you drink alcohol?	❑	❑
If yes, do you drink: ❑beer ❑wine ❑liquor ❑rarely ❑weekly ❑daily # of drinks _____		
22. Have you been drunk in the past month?	❑	❑
23 Do you ever drive a vehicle when drinking?	❑	❑
24. Do you ever use recreational drugs?	❑	❑
25. Do you always use a seatbelt when in a car?	❑	❑
26. Are there guns in the house?	❑	❑

History Update	Yes	No
27. Has there been a change in your medical history? _____	❑	❑
28. Has there been a change in your family medical history _____	❑	❑
29. Has there been a change in your household situation? _____	❑	❑

Comments (Please Print)	Yes	No
30. Do you have any concerns you wish to discuss?	❑	❑

Signature
X

Date MM/DD/YY
/ /

Time 00:00 AM/PM
: