SCREENING RECORD CHMPC

Children's Hospital Medical Practice Corporation

Name
Date of Birth
Chart No.

12 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
PDQ Questionnaire: ❑Normal ❑Abnormal ❑Referral
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

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 ❑ Hips
❑ Musculoskeletal
❑ Back
❑ Neuro

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

Assessment: _____

Plan: ❑MMRV or ❑MMR ❑Var ❑Hib ❑Hep A ❑Flu ❑PCV13 ❑Lead ❑Hgb or CBC _____ 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 :

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Parent Section
12 Month

SECTION TO BE COMPLETED BY PARENT

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

	Yes	No
1. Squeal, babble and imitate words & sounds?	❑	❑
2. Make sounds like "ma ma" and "da da"?	❑	❑
3. Show fear, anger, affection, jealousy?	❑	❑
4. Become shy or anxious with strangers?	❑	❑
5. Finger feed using thumb and finger?	❑	❑
6. Walk with minimal or no assistance?	❑	❑
7. Creep up stairs?	❑	❑
8. Ride in a rear-facing infant car seat?	❑	❑

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

9. Feedings?	❑	❑
10. Excessive spitting or vomiting?	❑	❑
11. Bowel movements?	❑	❑
12. Congestion or wheezing?	❑	❑
13. Sleep habits?	❑	❑
14. Excessive whining, fussing or crying?	❑	❑

15. Is your child attending day care?	❑	❑

Parent Section
❑ Mother ❑ Father ❑ Other _____

16. Do you have smoke alarms in your house?	❑	❑

Environmental Screening
Does your child….

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

History Update

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

Parent Comments (Please Print)

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

Signature
X

Date MM/DD/YY
/ /

Time 00:00 AM/PM
: