SCREENING RECORD CHMPC

Children's Hospital Medical Practice Corporation

Name
Date of Birth
Chart No.

16-18 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.
Patient section reviewed? ❑ Yes ❑ No ❑ 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

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: ❑ 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

_____

_____

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, 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 :

SCREENING RECORD
CHMPC
Children's Hospital Medical Practice Corporation

Name
Date of Birth
Chart No.

Patient Section
16-18 Year Male

SECTION TO BE COMPLETED BY PATIENT

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

	Yes	No
1. School/work: (circle) grades, motivation, concentration, completing assignments?	❑	❑
2. Lesions, sores or drainage from penis, swelling, tenderness or pain in groin, scrotum or testicles?	❑	❑
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?	❑	❑

Personal/Social

	Yes	No
17. Are you sexually active now?	❑	❑
If yes, do you always use a condom?	❑	❑
18. Do you use cigarettes, smokeless tobaco?	❑	❑
19. Do you drink alcohol?	❑	❑
If yes, do you drink: ❑ beer ❑ wine ❑ liquor ❑rarely ❑weekly ❑daily # of drinks _____		
20. Have you been drunk in the past month?	❑	❑
21. Do you ever drive a vehicle when drinking?	❑	❑
22. Do you ever use recreational drugs?	❑	❑
23. Do you always use a seatbelt when in a car?	❑	❑
24. Are there any guns in the house?	❑	❑

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

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

Signature
X

Date MM/DD/YY
/ /

Time 00:00 AM/PM
: