# SCREENING RECORD CHMPC

Children's Hospital Medical Practice Corporation

**Name**
**Date of Birth**
**Chart No.**

# 19-21 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** | / / | : |

SCREENING RECORD
CHMPC
Children's Hospital Medical Practice Corporation

Name
Date of Birth
Chart No.

# Patient Section
# 19-21 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 or 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. 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
: