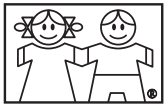


# SCREENING RECORD

# CHMPC

Children's Hospital Medical Practice Corporation



Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Chart No. \_\_\_\_\_

## 2 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

Metabolic Screen? ☐ Normal ☐ Abnormal ☐ Re-draw ☐ Counseled

Nutrition: ☐ Breast ☐ Formula Type \_\_\_\_\_ ☐ Vitamin D

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

Problems: \_\_\_\_\_

**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 ☐ Hips

☐ Musculoskeletal

☐ Back

☐ Neuro

**Anticipatory Guidance:** ☐ Sleep Issues ☐ Home Safety ☐ Car Safety ☐ Nutrition  
☐ Immunization Information ☐ Medication Education (if applicable)

**Assessment:** \_\_\_\_\_

**Plan:** ☐ DTaP/Hib/IPV ☐ Hep B ☐ PCV 13 ☐ Rota

☐ 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

:

## Parent Section 2 Month

### SECTION TO BE COMPLETED BY PARENT

#### Personal/Social History

*Does your child...*(check appropriate box for each question)

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 1. Respond to your face?                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Smile at the sound of your voice or seeing your face? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Coo or vocalize when you talk to him/ her?            | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Startle at loud noises?                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Move all extremities well?                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Sleep on his/her back?                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Ride in a rear-facing infant car seat?                | <input type="checkbox"/> | <input type="checkbox"/> |

*Are you **CONCERNED** about your child's...*

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 8. Feedings?                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Excessive spitting or vomiting?            | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Bowel movements?                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Nasal stuffiness, congestion or wheezing? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Skin color or skin rashes (circle)?       | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Excessive crying?                         | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Sleep habits?                             | <input type="checkbox"/> | <input type="checkbox"/> |

15. Will your child be attending day care? ☐ Yes ☐ No

#### Parent Section

☐ Mother ☐ Father ☐ Other \_\_\_\_\_

- |   |                          |                          |
|---|--------------------------|--------------------------|
| 16. Are you getting enough rest?                | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Have you been sad, depressed, crying a lot? | <input type="checkbox"/> | <input type="checkbox"/> |

#### Environmental Screening

*Does your child...*

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 18. Live in or regularly visit a house built before 1950 (daycare, baby sitter or relative)?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Live in or regularly visit a house built before 1978 with recent or ongoing renovation or remodeling (within the past 6 months)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Have a sibling or playmate who now has or did have lead poisoning?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Does anyone smoke in the household?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Do you have a swimming pool?   | <input type="checkbox"/> | <input type="checkbox"/> |

#### History Update

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 23. Has there been a change in your child's medical history?        | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Has there been a change in your child's family medical history? | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Change in household situation?                                  | <input type="checkbox"/> | <input type="checkbox"/> |

#### Parent Comments (Please Print)

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 26. Do you have any concerns you wish to discuss? | <input type="checkbox"/> | <input type="checkbox"/> |

Signature

X

Date MM/DD/YY

/ /

Time 00:00 AM/PM

: