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 :

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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?	❑	❑
2. Smile at the sound of your voice or seeing your face?	❑	❑
3. Coo or vocalize when you talk to him/ her?	❑	❑
4. Startle at loud noises?	❑	❑
5. Move all extremities well?	❑	❑
6. Sleep on his/her back?	❑	❑
7. Ride in a rear-facing infant car seat?	❑	❑

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

8. Feedings?	❑	❑
9. Excessive spitting or vomiting?	❑	❑
10. Bowel movements?	❑	❑
11. Nasal stuffiness, congestion or wheezing?	❑	❑
12. Skin color or skin rashes (circle)?	❑	❑
13. Excessive crying?	❑	❑
14. Sleep habits?	❑	❑

15. Will your child be attending day care?	❑	❑

Parent Section
❑Mother ❑Father ❑Other _____

16. Are you getting enough rest?	❑	❑
17. Have you been sad, depressed, crying a lot?	❑	❑

Environmental Screening
Does your child….

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

History Update

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

Parent Comments (Please Print)

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

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Signature
X

Date MM/DD/YY
/ /

Time 00:00 AM/PM
: