SCREENING RECORD CHMPC

Children's Hospital Medical Practice Corporation

Name
Date of Birth
Chart No.

3 Year

Date_____ Time _____
Actual Age_____ Weight _____lb _____ oz. Height _____in. BMI_____
Temp _____ Pulse _____ Resp _____ BP _____ Pain Score (0 – 5) _____
❑ Environmental Screen ❑ Lead Risk Assessment ❑ Growth chart plotted
PDQ Questionnaire: ❑ Normal ❑ Abnormal ❑ Referral
Nutrition: ❑ 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

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

Anticipatory Guidance: ❑ Home Safety ❑ Car Safety ❑ Dental ❑ Behavior
❑ Nutrition ❑ Medication Education (if applicable) ❑ Educational Handouts

Assessment: _____

Plan: ❑ Flu ❑ Hgb or CBC (If necessary _____ value) ❑ Counseled
❑ Urine Screen (if necessary) ❑ UTO ❑ WNL ❑ Lead (if necessary) ____
❑ 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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PATIENT DATA

Parent Section
3 Year

SECTION TO BE COMPLETED BY PARENT

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

	Yes	No
1. Talk well, using 3 –5 word sentences?	❑	❑
2. Count to 5 or more?	❑	❑
3. Know 4 or more colors?	❑	❑
4. Talk on the telephone?	❑	❑
5. Sing simple songs?	❑	❑
6. Play "make believe" at times?	❑	❑
7. Skip or hop on one foot?	❑	❑
8. Ride a tricycle?	❑	❑
9. Walk up and down stairs on alternate feet?	❑	❑
10. Dress or undress with minimal assistance?	❑	❑

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

11. Eating habits, sleeping?	❑	❑
12. Frequent colds or ear infections?	❑	❑
13. Abdominal pain, vomiting, diarrhea?	❑	❑
14. Does your child ride in a safety seat in the rear?	❑	❑
15. Is your child attending daycare?	❑	❑
16. Are there guns in the 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
❑ Mother ❑ Father ❑ Other		
25. Do you have any concerns you wish to discuss?	❑	❑

Signature
X

Date MM/DD/YY
/ /

Time 00:00 AM/PM
: