# SCREENING RECORD CHMPC

Children's Hospital Medical Practice Corporation

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

# 4-5 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
❑ Educational handouts ❑ Guns/trigger locks ❑ Immunizations ❑ Medication Education (if applicable)

**Assessment:** _____

**Plan:** ❑ DTaP ❑ IPV ❑ MMRV or MMR ❑ Var ❑ Flu ❑ Hgb or CBC (If necessary _____ value) ❑ Counseled
❑ Lead (if necessary) _____ ❑ Urine Screen (if necessary) ❑ UTO ❑ WNL
❑ Hearing Objective: Pass _____ Fail _____ ❑ Vision Objective: Right _____ Left _____ ❑ Glasses/contacts
❑ 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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Name
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*PATIENT DATA*

# Parent Section
# 4-5 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 long meaningful sentences? | ❑ | ❑ |
| 2. Tell simple stories and nursery rhymes? | ❑ | ❑ |
| 3. Know full name, address, phone number, 911? | ❑ | ❑ |
| 4. Create imaginary stories, fantasies, situations? | ❑ | ❑ |
| 5. Skip or hop on one foot 4-5 times? | ❑ | ❑ |
| 6. Stack 10 or more blocks? | ❑ | ❑ |
| 7. Use crayons or scissors well? | ❑ | ❑ |
| 8. Dress self without supervision? | ❑ | ❑ |

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

| | | |
|---|---|---|
| 9. Eating habits, sleeping? | ❑ | ❑ |
| 10. Frequent colds or ear infections? | ❑ | ❑ |
| 11. Abdominal pain, vomiting, diarrhea? | ❑ | ❑ |
| 12. Ability to sit still and listen? | ❑ | ❑ |
| 13. Pre-school performance or school readiness? | ❑ | ❑ |
| 14. Does he/she ride in a safety seat in the rear? | ❑ | ❑ |
| 15. Are there guns in the house? | ❑ | ❑ |

**Environmental Screening**
***Does your child….***

| | Yes | No |
|---|---|---|
| 16. Live in or regularly visit a house built before 1950 (daycare, baby sitter or relative)? | ❑ | ❑ |
| 17. Live in or regularly visit a house built before 1978 with recent or ongoing renovation or remodeling (within the past 6 months)? | ❑ | ❑ |
| 18. Have a sibling or playmate who now has or did have lead poisoning? | ❑ | ❑ |
| 19. Does anyone smoke in the household? | ❑ | ❑ |
| 20. Do you have a swimming pool? | ❑ | ❑ |

| **History Update** | Yes | No |
|---|---|---|
| 21. Has there been a change in your child's medical history? | ❑ | ❑ |
| 22. Has there been a change in your child's family medical history | ❑ | ❑ |
| 23. Change in household situation? | ❑ | ❑ |

| **Parent Comments (Please Print)** | Yes | No |
|---|---|---|
| ❑ Mother ❑ Father ❑ Other | | |
| 24. Do you have any concerns you wish to discuss? | ❑ | ❑ |

**Signature**
**X**

**Date** MM/DD/YY
/ /

**Time** 00:00 AM/PM
: