SCREENING RECORD CHMPC

Children's Hospital Medical Practice Corporation

Name
Date of Birth
Chart No.

6-7 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
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: _____
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

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	
❑ Psych	❑ Suicide Risk Assessment

Anticipatory Guidance: ❑ Nutrition ❑ Dental ❑ School ❑ Initiated PSC-17 ❑ Home Safety/ Playground ❑ Car Safety
❑ Educational handouts ❑ Guns/trigger locks ❑ Medication Education (if applicable)

Assessment: _____

Plan: ❑ Flu ❑ Hgb or CBC (If necessary _____ value) ❑ Counseled
❑ Urine Screen (if necessary) ❑ UTO ❑ WNL
❑ Hearing Objective: Pass _____ Fail _____ ❑ Vision Objective: Right _____ Left _____ ❑ Glasses/contacts
❑ Color Perception: 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
6-7 Year

SECTION TO BE COMPLETED BY PARENT

Personal/Social History
Are you <u>CONCERNED</u> about your child's...
(check appropriate box for each question)

	Yes	No
1. Overall progress in school?	❑	❑
2. Ability to sit still, listen or participate?	❑	❑
3. Willingness to follow rules at school?	❑	❑
4. Ability to get along with peers and teachers?	❑	❑
5. School attendance?	❑	❑
6. Eating habits (excessive or improper snacks)?	❑	❑
7. Sleep habits (nightmares, sleep walking)?	❑	❑
8. Energy level or stamina?	❑	❑
9. Frequent colds or ear infections, allergies?	❑	❑
10. Frequent bouts of abdominal pain, vomiting, diarrhea?	❑	❑
11. Does your child have adult supervision before and after school?	❑	❑
12. Does your child use a helmet for skating?	❑	❑
13. Does your child use a booster and ride in the back seat?	❑	❑
14. Are there guns in the house?	❑	❑

Environmental Screening
Does your child....

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

History Update

	Yes	No
20. Has there been a change in your child's medical history?	❑	❑
21. Has there been a change in your child's family medical history	❑	❑
22. Change in household situation?	❑	❑

Parent Comments (Please Print)
❑ Mother ❑ Father ❑ Other

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

Signature
X

Date MM/DD/YY
/ /

Time 00:00 AM/PM
: