SCREENING RECORD CHMPC

Children's Hospital Medical Practice Corporation

Name
Date of Birth
Chart No.

8-9 Year

Date_____ Time _____
Actual Age_____ Weight _____lb _____ oz. Height _____in. BMI_____
Temp _____ Pulse _____ Resp _____ BP _____ Pain Score (0 – 5) _____
❑ Environmental Screen ❑ 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) ❑ Immunization Information
Assessment: _____

Plan: ❑ Flu ❑ HPV ❑ 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 (if necessary): 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 :

SCREENING RECORD
CHMPC
Children's Hospital Medical Practice Corporation

Name
Date of Birth
Chart No.

Parent Section
8-9 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. Happiness, self esteem, self confidence?	❑	❑
3. Ability to sit still, listen or participate?	❑	❑
4. Progress in reading or math?	❑	❑
5. Willingness to follow rules at school?	❑	❑
6. Ability to get along with peers and teachers?	❑	❑
7. School attendance?	❑	❑
8 Overall health and development?	❑	❑
9. Irritability, temper, outbursts, excessive anger?	❑	❑
10. Eating habits, weight loss, loss of energy, sleep habits?	❑	❑
11. Recurrent ear, sinus or throat infections, nosebleeds?	❑	❑
12. Chest pain, shortness of breath, or irregular heartbeat?	❑	❑
13. Frequent colds, cough, wheezing, recurrent bronchitis?	❑	❑
14. Abdominal pain, vomiting, diarrhea, constipation?	❑	❑
15. Urinary control, bed wetting, urinary infections?	❑	❑
16. Joint pain, stiffness, swelling, muscle pain, weakness?	❑	❑
17. Birthmarks, skin rashes, itching, nail or hair problems?	❑	❑
18. Recurrent headaches, dizziness, tics, weak, seizures?	❑	❑
19. Mood changes, sadness, nervous problems?	❑	❑
20. Excessive thirst or hunger, increased urination, weight loss?	❑	❑
21. Paleness, anemia, easy bruising, swollen glands?	❑	❑
22. Milk, food or drug allergies, recurrent infections?	❑	❑

Environmental Screening
Does your child….

	Yes	No
23. Does he/she have adult supervision before and after school?	❑	❑
24. Exercise on a regular basis?	❑	❑
25. Use a helmet skating and biking?	❑	❑
26. Use a booster seat, ride in the back?	❑	❑
27. Does anyone in the household smoke?	❑	❑
28. Do you counsel him/ her about avoiding the use of alcohol, tobacco, drugs and inhalants?	❑	❑
29. Are there guns in the house?	❑	❑
30. Do you have a swimming pool?	❑	❑

History Update	Yes	No
31. Has there been a change in your child's medical history?	❑	❑
32. Has there been a change in your child's family medical history	❑	❑
33. Change in household situation?	❑	❑

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

Signature
X

Date MM/DD/YY
/ /

Time 00:00 AM/PM
: