SCREENING RECORD CHMPC

Children's Hospital Medical Practice Corporation

Name
Date of Birth
Chart No.

9 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
Nutrition: ❑Breast ❑Formula Type _____ ❑Solids ❑Vitamins ❑Fluoride
Adverse Reactions (drug allergies): ❑Yes* _____ ❑No *If yes, also list on Patient Problem Summary in front of chart.
❑Parent section reviewed? ❑Parent 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 ❑ Hips
❑ Musculoskeletal
❑ Back
❑ Neuro

Anticipatory Guidance: ❑ Home Safety ❑ Car Safety ❑ Poisons ❑Nutrition
❑ Immunization Information ❑ Medication Education (if applicable)

Assessment: _____

Plan: ❑Flu
❑ 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 :

SCREENING RECORD
CHMPC
Children's Hospital Medical Practice Corporation

Name
Date of Birth
Chart No.

Parent Section
9 Month

SECTION TO BE COMPLETED BY PARENT

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

	Yes	No
1. Squeal, babble and imitate sounds?	❑	❑
2. Seem to hear well?	❑	❑
3. Move all extremities well?	❑	❑
4. Explore objects by shaking, banging or throwing?	❑	❑
5. Try to pick up objects with thumb and finger?	❑	❑
6. Pull to a standing position?	❑	❑
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. Congestion or wheezing?	❑	❑
12. Sleep habits?	❑	❑
13. Is your child attending day care?	❑	❑

Environmental Screening
Does your child….

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

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

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

Signature
X

Date MM/DD/YY
/ /

Time 00:00 AM/PM
: