

COMPREHENSIVE HEALTH ASSESSMENT FORMS

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COMPREHENSIVE HEALTH ASSESSMENT FORMS

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Comprehensive Health Assessment

1 to 2 Months Old	Actual Age: _____ Date: _____
Sex at Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female
Accompanied by	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other: _____
Parent's Primary Language	_____
Interpreter Requested	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused Name of Interpreter: _____
Intake	(See WHO Growth Chart) Vital Signs
Head Circumference	Temp _____
Length	Pulse _____
Weight	Resp _____
Allergies / Reaction	_____
Pain	Location: _____ Scale: 0 1 2 3 4 5 6 7 8 9 10
Cultural Needs (e.g., cultural background/traditions, religious practices, dietary preference/restrictions, and healthcare beliefs):	<input type="checkbox"/> Unremarkable
Birth Weight: _____ Birth Length: _____ Gestational Age: _____ Delivery: <input type="checkbox"/> Vaginal <input type="checkbox"/> C-section Complications: <input type="checkbox"/> Yes <input type="checkbox"/> No Country of Birth: <input type="checkbox"/> US <input type="checkbox"/> Other: _____ At least 1 parent born in Africa, Asia, Pacific Islands: <input type="checkbox"/> Yes <input type="checkbox"/> No	
OB/GYN Provider: Post-Partum Appointment Date:	
Chronic Problems/Significant Conditions: <input type="checkbox"/> None <input type="checkbox"/> See Problem List <input type="checkbox"/> DM <input type="checkbox"/> Dialysis <input type="checkbox"/> Heart Disease <input type="checkbox"/> HEP B <input type="checkbox"/> HEP C <input type="checkbox"/> HIV <input type="checkbox"/> Liver Disease <input type="checkbox"/> Seizures <input type="checkbox"/> Uses DME <input type="checkbox"/> ≥ 2 ER visits in 12 months <input type="checkbox"/> Other: _____	
Current Medications/Vitamins: <input type="checkbox"/> See Medication List	
Interval History	
Feedings	<input type="checkbox"/> Breastfed every _____ hours <input type="checkbox"/> Formula _____ oz every _____ hours Formula Type or Brand: _____
Elimination	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Has WIC	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sleep	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Sleep Position	<input type="checkbox"/> Supine <input type="checkbox"/> Prone <input type="checkbox"/> Side
Vaccines Up to Date	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> See CAIR
Family History	<input type="checkbox"/> Unremarkable <input type="checkbox"/> Diabetes
<input type="checkbox"/> Heart disease / HTN	<input type="checkbox"/> Lives/lived with someone HBV+ <input type="checkbox"/> Born to HBV+ parents
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Cancer <input type="checkbox"/> Family Hx of unexpected or sudden death < 50 yrs
<input type="checkbox"/> Other: _____	
Dyadic Behavioral / Social Determinants of Health (SDOH)	<input type="checkbox"/> WNL - Stable relationships w/ social/emotional support <input type="checkbox"/> Changes in family since last visit (move, job, death) <input type="checkbox"/> Problems with housing, food, employment <input type="checkbox"/> Family stressors (mental illness, drugs, violence/abuse)
Lives with	<input type="checkbox"/> 1 Parent <input type="checkbox"/> 2 Parents <input type="checkbox"/> Other: _____

Name: _____ DOB: _____ MR#: _____

AAP Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/Orders/AG)
Adverse Childhood Experiences	<input type="checkbox"/> PEARLS , <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Dyadic Behavioral / SDOH	<input type="checkbox"/> SDOH , <input type="checkbox"/> PEARLS , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B	<input type="checkbox"/> CDC HEP Risk , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Maternal Depression Score: _____	<input type="checkbox"/> EPDS , <input type="checkbox"/> PHQ-9 , <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco Use / Exposure	<input type="checkbox"/> SHA , <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis Exposure	<input type="checkbox"/> TB Risk Assessment , <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Growth and Development			
<input type="checkbox"/> Prone, lifts head 45°	<input type="checkbox"/> Vocalizes (cooing)	<input type="checkbox"/> Grasps rattle	
<input type="checkbox"/> Kicks	<input type="checkbox"/> Follows past midline	<input type="checkbox"/> Smiles responsively (social)	
Physical Examination			WNL
General appearance	Well-nourished & developed No abuse/neglect evident	<input type="checkbox"/>	
Head	Symmetrical, A.F. open _____ cm	<input type="checkbox"/>	
Eyes	PERRLA, conjunctivae & sclerae clear Red reflexes present, No strabismus Appears to see	<input type="checkbox"/>	
Ears	Canals clear, TMs normal Appears to hear	<input type="checkbox"/>	
Nose	Passages clear, MM pink, no lesions	<input type="checkbox"/>	
Mouth / Pharynx	Oral mucosa pink, no lesions	<input type="checkbox"/>	
Neck	Supple, no masses, thyroid not enlarged	<input type="checkbox"/>	
Chest	Symmetrical, no masses	<input type="checkbox"/>	
Heart	No organic murmurs, regular rhythm	<input type="checkbox"/>	
Lungs	Clear to auscultation bilaterally	<input type="checkbox"/>	
Abdomen	Soft, no masses, liver & spleen normal	<input type="checkbox"/>	
Genitalia	Grossly normal	<input type="checkbox"/>	
Male	Circ / uncircumcised, testes in scrotum	<input type="checkbox"/>	
Female	No lesions, normal external appearance	<input type="checkbox"/>	
Hips	Good abduction, leg lengths equal	<input type="checkbox"/>	
Femoral pulses	Present and equal	<input type="checkbox"/>	
Extremities	No deformities, full ROM	<input type="checkbox"/>	
Skin	Clear, no significant lesions	<input type="checkbox"/>	
Neurologic	Alert, no gross sensory or motor deficit	<input type="checkbox"/>	
Subjective / Objective			

Comprehensive Health Assessment

3 to 4 Months Old	Actual Age: _____ Date: _____
Sex at Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female
Accompanied by	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other: _____
Parent's Primary Language	_____
Interpreter Requested	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused Name of Interpreter: _____
Intake	(See WHO Growth Chart) Vital Signs
Head Circumference	Temp _____
Length	Pulse _____
Weight	Resp _____
Allergies / Reaction	_____
Pain	Location: _____ Scale: 0 1 2 3 4 5 6 7 8 9 10
Cultural Needs (e.g., cultural background/traditions, religious practices, dietary preference/restrictions, and healthcare beliefs): <input type="checkbox"/> Unremarkable	
Birth Weight: _____ Birth Length: _____ Gestational Age: _____ Delivery: <input type="checkbox"/> Vaginal <input type="checkbox"/> C-section Complications: <input type="checkbox"/> Yes <input type="checkbox"/> No Country of Birth: <input type="checkbox"/> US <input type="checkbox"/> Other: _____ At least 1 parent born in Africa, Asia, Pacific Islands: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Delivery	<input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section Complications <input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic Problems/Significant Conditions: <input type="checkbox"/> None <input type="checkbox"/> See Problem List <input type="checkbox"/> DM <input type="checkbox"/> Dialysis <input type="checkbox"/> Heart Disease <input type="checkbox"/> HEP B <input type="checkbox"/> HEP C <input type="checkbox"/> HIV <input type="checkbox"/> Liver Disease <input type="checkbox"/> Seizures <input type="checkbox"/> Uses DME <input type="checkbox"/> ≥ 2 ER visits in 12 months <input type="checkbox"/> Other: _____	
Current Medications/Vitamins: <input type="checkbox"/> See Medication List	
Interval History	
Feedings	<input type="checkbox"/> Breastfed every _____ hours <input type="checkbox"/> Formula _____ oz every _____ hours Formula Type or Brand: _____
Elimination	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Has WIC	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sleep	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Sleep Position	<input type="checkbox"/> Supine <input type="checkbox"/> Prone <input type="checkbox"/> Side
Vaccines Up to Date	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> See CAIR
Family History	<input type="checkbox"/> Unremarkable <input type="checkbox"/> Diabetes
<input type="checkbox"/> Heart disease / HTN	<input type="checkbox"/> Lives/lived with someone HBV+ <input type="checkbox"/> Born to HBV+ parents
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Cancer <input type="checkbox"/> Family Hx of unexpected or sudden death < 50 yrs
<input type="checkbox"/> Anemia	<input type="checkbox"/> Other: _____
Dyadic Behavioral / Social Determinants of Health (SDOH)	<input type="checkbox"/> WNL - Stable relationships w/ social/emotional support <input type="checkbox"/> Changes in family since last visit (move, job, death) <input type="checkbox"/> Problems with housing, food, employment <input type="checkbox"/> Family stressors (mental illness, drugs, violence/abuse)
Lives with	<input type="checkbox"/> 1 Parent <input type="checkbox"/> 2 Parents <input type="checkbox"/> Other: _____

Name: _____ DOB: _____ MR#: _____

AAP Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/Orders/AG)
Adverse Childhood Experiences	<input type="checkbox"/> PEARLS, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Dyadic Behavioral / SDOH	<input type="checkbox"/> SDOH, <input type="checkbox"/> PEARLS, <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B	<input type="checkbox"/> CDC HEP Risk, <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Maternal Depression Score: _____	<input type="checkbox"/> EPDS, <input type="checkbox"/> PHQ-9, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco Use / Exposure	<input type="checkbox"/> SHA, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis Exposure	<input type="checkbox"/> TB Risk Screener, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Growth and Development			
<input type="checkbox"/> Head steady when sitting	<input type="checkbox"/> Squeals or coos	<input type="checkbox"/> Orients to voices	
<input type="checkbox"/> Eyes follow 180°	<input type="checkbox"/> Rolls form stomach to back	<input type="checkbox"/> Brings hands together	
<input type="checkbox"/> Grasps rattle	<input type="checkbox"/> Gums objects	<input type="checkbox"/> Laughs aloud	
Physical Examination			WNL
General appearance	Well-nourished & developed No abuse/neglect evident		<input type="checkbox"/>
Head	Symmetrical, A.F. open _____ cm		<input type="checkbox"/>
Eyes	PERRLA, conjunctivae & sclerae clear Red reflexes present, No strabismus Appears to see		<input type="checkbox"/>
Ears	Canals clear, TMs normal Appears to hear		<input type="checkbox"/>
Nose	Passages clear, MM pink, no lesions		<input type="checkbox"/>
Mouth / Pharynx	Oral mucosa pink, no lesions		<input type="checkbox"/>
Neck	Supple, no masses, thyroid not enlarged		<input type="checkbox"/>
Chest	Symmetrical, no masses		<input type="checkbox"/>
Heart	No organic murmurs, regular rhythm		<input type="checkbox"/>
Lungs	Clear to auscultation bilaterally		<input type="checkbox"/>
Abdomen	Soft, no masses, liver & spleen normal		<input type="checkbox"/>
Genitalia	Grossly normal		<input type="checkbox"/>
Male	Circ / uncircumcised, testes in scrotum		<input type="checkbox"/>
Female	No lesions, normal external appearance		<input type="checkbox"/>
Hips	Good abduction, leg lengths equal		<input type="checkbox"/>
Femoral pulses	Present and equal		<input type="checkbox"/>
Extremities	No deformities, full ROM		<input type="checkbox"/>
Skin	Clear, no significant lesions		<input type="checkbox"/>
Neurologic	Alert, no gross sensory or motor deficit		<input type="checkbox"/>

Comprehensive Health Assessment

5 to 6 Months Old	Actual Age: _____ Date: _____
Sex at Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female
Accompanied by	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other: _____
Parent's Primary Language	_____
Interpreter Requested	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused Name of Interpreter: _____
Intake	(See WHO Growth Chart) Vital Signs
Head Circumference	Temp _____
Length	Pulse _____
Weight	Resp _____
Allergies / Reaction	_____
Pain	Location: _____ Scale: 0 1 2 3 4 5 6 7 8 9 10
Cultural Needs (e.g., cultural background/traditions, religious practices, dietary preference/restrictions, and healthcare beliefs): <input type="checkbox"/> Unremarkable	
Birth Weight: _____ Birth Length: _____ Gestational Age: _____ Delivery: <input type="checkbox"/> Vaginal <input type="checkbox"/> C-section Complications: <input type="checkbox"/> Yes <input type="checkbox"/> No Country of Birth: <input type="checkbox"/> US <input type="checkbox"/> Other: _____ At least 1 parent born in Africa, Asia, Pacific Islands: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Chronic Problems/Significant Conditions: <input type="checkbox"/> None <input type="checkbox"/> See Problem List <input type="checkbox"/> DM <input type="checkbox"/> Dialysis <input type="checkbox"/> Heart Disease <input type="checkbox"/> HEP B <input type="checkbox"/> HEP C <input type="checkbox"/> HIV <input type="checkbox"/> Liver Disease <input type="checkbox"/> Seizures <input type="checkbox"/> Uses DME <input type="checkbox"/> ≥ 2 ER visits in 12 months <input type="checkbox"/> Other: _____	
Current Medications/Vitamins: <input type="checkbox"/> See Medication List	
Interval History	
Feedings	<input type="checkbox"/> Breastfed every _____ hours <input type="checkbox"/> Formula _____ oz every _____ hours Formula Type or Brand: _____
Elimination	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Has WIC	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sleep	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Sleep Position	<input type="checkbox"/> Supine <input type="checkbox"/> Prone <input type="checkbox"/> Side
Fluoride Use	Drinks fluoridated water or takes supplements: <input type="checkbox"/> Yes <input type="checkbox"/> No
Fluoride Varnish	Applied to teeth within last 6 months: <input type="checkbox"/> Yes <input type="checkbox"/> No
Vaccines Up to Date	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> See CAIR
Family History	<input type="checkbox"/> Unremarkable <input type="checkbox"/> Diabetes
<input type="checkbox"/> Heart disease / HTN	<input type="checkbox"/> Lives/lived with someone HBV+ <input type="checkbox"/> Born to HBV+ parents
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Cancer <input type="checkbox"/> Family Hx of unexpected or sudden death < 50 yrs
<input type="checkbox"/> Other: _____	
Dyadic Behavioral / Social Determinants of Health (SDOH)	<input type="checkbox"/> WNL - Stable relationships w/ social/emotional support <input type="checkbox"/> Changes in family since last visit (move, job, death) <input type="checkbox"/> Problems with housing, food, employment <input type="checkbox"/> Family stressors (mental illness, drugs, violence/abuse)
Lives with	<input type="checkbox"/> 1 Parent <input type="checkbox"/> 2 Parents <input type="checkbox"/> Other: _____

Name: _____

DOB: _____

MR#: _____

AAP Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/Orders/AG)
Adverse Childhood Experiences	<input type="checkbox"/> PEARLS , <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Blood Lead Education (Start at 6 months)	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Dyadic Behavioral / SDOH	<input type="checkbox"/> SDOH , <input type="checkbox"/> PEARLS , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B	<input type="checkbox"/> CDC HEP Risk , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Maternal Depression Score: _____	<input type="checkbox"/> EPDS , <input type="checkbox"/> PHQ-9 , <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco Use / Exposure	<input type="checkbox"/> SHA , <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis Exposure	<input type="checkbox"/> TB Risk Assessment , <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Growth and Development			
<input type="checkbox"/> No head lag when pulled to sitting	<input type="checkbox"/> Sits briefly alone	<input type="checkbox"/> Orients to bell	
<input type="checkbox"/> Bears weight on legs	<input type="checkbox"/> Rolls both ways	<input type="checkbox"/> Bangs small objects on surface	
<input type="checkbox"/> Reaches for objects	<input type="checkbox"/> Gums objects	<input type="checkbox"/> Babbles	
Physical Examination			WNL
General appearance	Well-nourished & developed No abuse/neglect evident	<input type="checkbox"/>	
Head	Symmetrical, A.F. open _____ cm	<input type="checkbox"/>	
Eyes	PERLLA, conjunctivae & sclerae clear Red reflexes present, No strabismus Appears to see	<input type="checkbox"/>	
Ears	Canals clear, TMs normal Appears to hear	<input type="checkbox"/>	
Nose	Passages clear, MM pink, no lesions	<input type="checkbox"/>	
Teeth	Present, grossly normal, No visible cavities	<input type="checkbox"/>	
Mouth / Pharynx	Oral mucosa pink, no lesions	<input type="checkbox"/>	
Neck	Supple, no masses, Thyroid not enlarged	<input type="checkbox"/>	
Chest / Breast	Symmetrical, no masses	<input type="checkbox"/>	
Heart	No organic murmurs, regular rhythm	<input type="checkbox"/>	
Lungs	Clear to auscultation bilaterally	<input type="checkbox"/>	
Abdomen	Soft, no masses, liver & spleen normal	<input type="checkbox"/>	
Genitalia	Grossly normal	<input type="checkbox"/>	
Male	Circ / uncircumcised, testes in scrotum	<input type="checkbox"/>	
Female	No lesions, normal external appearance	<input type="checkbox"/>	
Hips	Good abduction, leg lengths equal	<input type="checkbox"/>	
Femoral pulses	Normal	<input type="checkbox"/>	
Extremities	No deformities, full ROM	<input type="checkbox"/>	
Skin	Clear, no significant lesions	<input type="checkbox"/>	
Neurologic	Alert, no gross sensory or motor deficit	<input type="checkbox"/>	

Comprehensive Health Assessment

Subjective / Objective		
Assessment		
Plan		
Referrals		
<input type="checkbox"/> <u>WIC</u>	<input type="checkbox"/> Optometrist / Ophthalmologist	<input type="checkbox"/> Audiologist
<input type="checkbox"/> Maternal Behavioral Health	<input type="checkbox"/> Dietician / Nutritionist	<input type="checkbox"/> Pulmonologist
<input type="checkbox"/> Dentist	<input type="checkbox"/> Regional Center	<input type="checkbox"/> Early Start or Local Education Agency
<input type="checkbox"/> CA Children's Services (CCS)	<input type="checkbox"/> Other:	
Orders		
<input type="checkbox"/> COVID 19 vaccine	<input type="checkbox"/> IPV	<input type="checkbox"/> CBC / Basic metabolic panel
<input type="checkbox"/> DTaP	<input type="checkbox"/> PCV	<input type="checkbox"/> Hct / Hgb
<input type="checkbox"/> Hep A vaccine (if high risk)	<input type="checkbox"/> Rotavirus	<input type="checkbox"/> PPD skin test <input type="checkbox"/> QFT
<input type="checkbox"/> Hep B vaccine	<input type="checkbox"/> Hep B Panel (if high risk)	<input type="checkbox"/> CXR <input type="checkbox"/> Urinalysis
<input type="checkbox"/> Hib	<input type="checkbox"/> Rx Fluoride drops / chewable tabs (0.25 mg QD)	<input type="checkbox"/> ECG <input type="checkbox"/> COVID 19 test
<input type="checkbox"/> Influenza vaccine	<input type="checkbox"/> Fluoride varnish application	<input type="checkbox"/> Iron-fortified formula
<input type="checkbox"/> Other:		

Name: _____ **DOB:** _____ **MR#:** _____

Anticipatory Guidance (AG) / Education (✓ if discussed)		
Health education preference: <input type="checkbox"/> Verbal <input type="checkbox"/> Visual <input type="checkbox"/> Multimedia <input type="checkbox"/> Other:		
Diet, Nutrition & Exercise		
<input type="checkbox"/> Introduction to solids	<input type="checkbox"/> Fortified Infant Cereals	<input type="checkbox"/> Start solid foods one at a time
<input type="checkbox"/> Breastfeeding / formula	<input type="checkbox"/> No cow's milk	<input type="checkbox"/> Start feeder cup
Accident Prevention & Guidance		
<input type="checkbox"/> <u>Lead poisoning prevention</u>	<input type="checkbox"/> Rear facing infant car seat	<input type="checkbox"/> Electrical outlet covers
<input type="checkbox"/> Routine dental care	<input type="checkbox"/> Choking hazards	<input type="checkbox"/> Blocks
<input type="checkbox"/> Brush teeth with fluoride toothpaste	<input type="checkbox"/> Storage of drugs / toxic chemicals	<input type="checkbox"/> Repetitive games
<input type="checkbox"/> Fluoride varnish treatment	<input type="checkbox"/> Matches / burns	<input type="checkbox"/> Play with cloth book
<input type="checkbox"/> Family support, social interaction & communication	<input type="checkbox"/> Violence prevention, gun safety	<input type="checkbox"/> Physical growth
<input type="checkbox"/> Caution with strangers	<input type="checkbox"/> Poison control phone number	<input type="checkbox"/> Bathing
<input type="checkbox"/> Skin cancer prevention	<input type="checkbox"/> Smoke detector	<input type="checkbox"/> Limit screen time
<input type="checkbox"/> Signs of maternal depression	<input type="checkbox"/> Hot water temp < 120° F	<input type="checkbox"/> Bedtime
<input type="checkbox"/> Effects of passive smoking	<input type="checkbox"/> Drowning / pool fence	<input type="checkbox"/> Teething
Next Appointment		
<input type="checkbox"/> At 9 Months Old	<input type="checkbox"/> RTC PRN	<input type="checkbox"/> Other:

Documentation Reminders		
<input type="checkbox"/> Screening tools (TB, HEP B, Maternal Depression, etc.) are completed, dated, & reviewed by provider	<input type="checkbox"/> Length, Weight & Head Circumference measurements plotted in WHO growth chart	<input type="checkbox"/> Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date
Provider Signature	Title	Date

Notes (include date, time, signature, and title on all entries)		
<input type="checkbox"/> Member/parent refused the following screening/orders:		

Comprehensive Health Assessment

7 to 9 Months Old	Actual Age: _____ Date: _____
Sex at Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female
Accompanied by	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other: _____
Parent's Primary Language	_____
Interpreter Requested	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused Name of Interpreter: _____
Intake	(See WHO Growth Chart) Vital Signs
Head Circumference	Temp _____
Length	Pulse _____
Weight	Resp _____
Allergies / Reaction	_____
Pain	Location: _____ Scale: 0 1 2 3 4 5 6 7 8 9 10
Cultural Needs (e.g., cultural background/traditions, religious practices, dietary preference/restrictions, and healthcare beliefs): <input type="checkbox"/> Unremarkable	
Birth Weight: _____ Birth Length: _____ Gestational Age: _____ Delivery: <input type="checkbox"/> Vaginal <input type="checkbox"/> C-section Complications: <input type="checkbox"/> Yes <input type="checkbox"/> No Country of Birth: <input type="checkbox"/> US <input type="checkbox"/> Other: _____ At least 1 parent born in Africa, Asia, Pacific Islands: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Chronic Problems/Significant Conditions: <input type="checkbox"/> None <input type="checkbox"/> See Problem List <input type="checkbox"/> DM <input type="checkbox"/> Dialysis <input type="checkbox"/> Heart Disease <input type="checkbox"/> HEP B <input type="checkbox"/> HEP C <input type="checkbox"/> HIV <input type="checkbox"/> Liver Disease <input type="checkbox"/> Seizures <input type="checkbox"/> Uses DME <input type="checkbox"/> ≥ 2 ER visits in 12 months <input type="checkbox"/> Other: _____	
Current Medications/Vitamins: <input type="checkbox"/> See Medication List	
Interval History	
Diet / Nutrition	<input type="checkbox"/> Regular <input type="checkbox"/> Iron-rich foods <input type="checkbox"/> Other: _____
Feedings	<input type="checkbox"/> Breastfed every _____ hours <input type="checkbox"/> Formula _____ oz every _____ hours Formula Type or Brand: _____
Elimination	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Has WIC	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sleep	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Sleep Position	<input type="checkbox"/> Supine <input type="checkbox"/> Prone <input type="checkbox"/> Side
Fluoride Use	Drinks fluoridated water or takes supplements: <input type="checkbox"/> Yes <input type="checkbox"/> No
Fluoride Varnish	Applied to teeth within last 6 months: <input type="checkbox"/> Yes <input type="checkbox"/> No
Vaccines Up to Date	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> See CAIR
Family History	<input type="checkbox"/> Unremarkable <input type="checkbox"/> Diabetes
<input type="checkbox"/> Heart disease / HTN	<input type="checkbox"/> Lives/lived with someone HBV+ <input type="checkbox"/> Born to HBV+ parents
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Cancer <input type="checkbox"/> Family Hx of unexpected or sudden death < 50 yrs
<input type="checkbox"/> Other: _____	
Dyadic Behavioral / Social Determinants of Health (SDOH)	<input type="checkbox"/> WNL - Stable relationships w/ social/emotional support <input type="checkbox"/> Changes in family since last visit (move, job, death) <input type="checkbox"/> Problems with housing, food, employment <input type="checkbox"/> Family stressors (mental illness, drugs, violence/abuse)
Lives with	<input type="checkbox"/> 1 Parent <input type="checkbox"/> 2 Parents <input type="checkbox"/> Other: _____

Name: _____ DOB: _____ MR#: _____

AAP Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/Orders/AG)
Adverse Childhood Experiences	<input type="checkbox"/> PEARLS , <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Blood Lead Education (At each Well Visit)	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Dental (cavities, no dental home)	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Developmental Disorder (At 9 months) Score: _____	<input type="checkbox"/> ASQ-3 , <input type="checkbox"/> SWYC , <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Dyadic Behavioral / SDOH	<input type="checkbox"/> SDOH , <input type="checkbox"/> PEARLS , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B	<input type="checkbox"/> CDC HEP Risk , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco Use / Exposure	<input type="checkbox"/> SHA , <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis Exposure	<input type="checkbox"/> TB Risk Assessment , <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Growth and Development			
<input type="checkbox"/> Sits without support	<input type="checkbox"/> Transfers object hand to hand	<input type="checkbox"/> Looks for toy dropped	
<input type="checkbox"/> Begins to crawl	<input type="checkbox"/> Rolls over	<input type="checkbox"/> Says "mama" or "dada"	
<input type="checkbox"/> Pulls to stand	<input type="checkbox"/> Feeds self, cracker	<input type="checkbox"/> Scribbles	
Physical Examination WNL			
General appearance	Well-nourished & developed No abuse/neglect evident		<input type="checkbox"/>
Head	Symmetrical, A.F. open _____ cm		<input type="checkbox"/>
Eyes	PERRLA, conjunctivae & sclerae clear Red reflexes present, No strabismus Appears to see		<input type="checkbox"/>
Ears	Canals clear, TMs normal Appears to hear		<input type="checkbox"/>
Nose	Passages clear, MM pink, no lesions		<input type="checkbox"/>
Teeth	Present, grossly normal, No visible cavities		<input type="checkbox"/>
Mouth / Pharynx	Oral mucosa pink, no lesions		<input type="checkbox"/>
Neck	Supple, no masses, thyroid not enlarged		<input type="checkbox"/>
Chest / Breast	Symmetrical, no masses		<input type="checkbox"/>
Heart	No organic murmurs, regular rhythm		<input type="checkbox"/>
Lungs	Clear to auscultation bilaterally		<input type="checkbox"/>
Abdomen	Soft, no masses, liver & spleen normal		<input type="checkbox"/>
Genitalia	Grossly normal		<input type="checkbox"/>
Male	Circ / uncircumcised, testes in scrotum		<input type="checkbox"/>
Female	No lesions, normal external appearance		<input type="checkbox"/>
Hips	Good abduction		<input type="checkbox"/>
Femoral pulses	Normal		<input type="checkbox"/>
Extremities	No deformities, full ROM		<input type="checkbox"/>
Skin	Clear, no significant lesions		<input type="checkbox"/>
Neurologic	Alert, no gross sensory or motor deficit		<input type="checkbox"/>

Comprehensive Health Assessment

Subjective / Objective		
Assessment		
Plan		
Referrals		
<input type="checkbox"/> WIC	<input type="checkbox"/> Optometrist / Ophthalmologist	<input type="checkbox"/> Audiologist
<input type="checkbox"/> Dentist	<input type="checkbox"/> Dietician / Nutritionist	<input type="checkbox"/> Pulmonologist
<input type="checkbox"/> CA Children's Services (CCS)	<input type="checkbox"/> Regional Center	<input type="checkbox"/> Early Start or Local Education Agency
<input type="checkbox"/> Other:		
Orders		
<input type="checkbox"/> COVID 19 vaccine	<input type="checkbox"/> Meningococcal (if high risk)	<input type="checkbox"/> CBC / Basic metabolic panel
<input type="checkbox"/> DTaP (if not up to date)	<input type="checkbox"/> MMR (if high risk)	<input type="checkbox"/> Hct / Hgb
<input type="checkbox"/> Hep A vaccine (if high risk)	<input type="checkbox"/> PCV (if not up to date)	<input type="checkbox"/> Lipid panel (if high risk)
<input type="checkbox"/> Hep B vaccine	<input type="checkbox"/> Rotavirus	<input type="checkbox"/> PPD skin test <input type="checkbox"/> QFT
<input type="checkbox"/> Hib (if not up to date)	<input type="checkbox"/> Hep B Panel (if high risk)	<input type="checkbox"/> CXR <input type="checkbox"/> Urinalysis
<input type="checkbox"/> Influenza vaccine	<input type="checkbox"/> Rx Fluoride drops / chewable tabs (0.25 mg QD)	<input type="checkbox"/> ECG <input type="checkbox"/> COVID 19 test
<input type="checkbox"/> IPV	<input type="checkbox"/> Fluoride varnish application	<input type="checkbox"/> Iron-fortified formula
<input type="checkbox"/> Other:		

Name: _____ **DOB:** _____ **MR#:** _____

Anticipatory Guidance (AG) / Education (✓ if discussed)		
Health education preference: <input type="checkbox"/> Verbal <input type="checkbox"/> Visual <input type="checkbox"/> Multimedia <input type="checkbox"/> Other:		
Diet, Nutrition & Exercise		
<input type="checkbox"/> Introduction to meats & proteins	<input type="checkbox"/> Fortified Infant Cereals	<input type="checkbox"/> Mashed table food
<input type="checkbox"/> Whole grains / iron-rich foods	<input type="checkbox"/> Finger foods	<input type="checkbox"/> Start feeder cup
<input type="checkbox"/> Physical activity / exercise	<input type="checkbox"/> Healthy food choices	<input type="checkbox"/> No bottles in bed
Accident Prevention & Guidance		
<input type="checkbox"/> Lead poisoning prevention	<input type="checkbox"/> Rear facing infant car seat	<input type="checkbox"/> Electrical outlet covers
<input type="checkbox"/> Routine dental care	<input type="checkbox"/> Choking hazards	<input type="checkbox"/> Allow to feed self
<input type="checkbox"/> Brush teeth with fluoride toothpaste	<input type="checkbox"/> Storage of drugs / toxic chemicals	<input type="checkbox"/> Understands "no" but not discipline
<input type="checkbox"/> Fluoride varnish treatment	<input type="checkbox"/> Matches / burns	<input type="checkbox"/> Play with cloth book
<input type="checkbox"/> Family support, social interaction & communication	<input type="checkbox"/> Violence prevention, gun safety	<input type="checkbox"/> Physical growth
<input type="checkbox"/> Childcare plan	<input type="checkbox"/> Poison control phone number	<input type="checkbox"/> Decreased appetite
<input type="checkbox"/> Skin cancer prevention	<input type="checkbox"/> Smoke detector	<input type="checkbox"/> Limit screen time
<input type="checkbox"/> Falls	<input type="checkbox"/> Hot water temp < 120° F	<input type="checkbox"/> Bedtime
<input type="checkbox"/> Effects of passive smoking	<input type="checkbox"/> Drowning / pool fence	<input type="checkbox"/> Teething
Next Appointment		
<input type="checkbox"/> At 12 Months Old	<input type="checkbox"/> RTC PRN	<input type="checkbox"/> Other:

Documentation Reminders		
<input type="checkbox"/> Screening tools (TB, HEP B, Developmental D/O, etc.) are completed, dated, & reviewed by provider	<input type="checkbox"/> Length, Weight & Head Circumference measurements plotted in WHO growth chart	<input type="checkbox"/> Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date
Provider Signature	Title	Date

Notes (include date, time, signature, and title on all entries)
<input type="checkbox"/> Member/parent refused the following screening/orders:

Comprehensive Health Assessment

12 to 15 Months Old	Actual Age: _____ Date: _____
Sex at Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female
Accompanied by	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other: _____
Parent's Primary Language	_____
Interpreter Requested	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused Name of Interpreter: _____
Intake	(See WHO Growth Chart) Vital Signs
Head Circumference	Temp _____
Length	Pulse _____
Weight	Resp _____
Allergies / Reaction	_____
Pain	Location: _____ Scale: 0 1 2 3 4 5 6 7 8 9 10
Cultural Needs (e.g., cultural background/traditions, religious practices, dietary preference/restrictions, and healthcare beliefs): <input type="checkbox"/> Unremarkable	
Birth Weight: _____ Birth Length: _____ Gestational Age: _____ Delivery: <input type="checkbox"/> Vaginal <input type="checkbox"/> C-section Complications: <input type="checkbox"/> Yes <input type="checkbox"/> No Country of Birth: <input type="checkbox"/> US <input type="checkbox"/> Other: _____ At least 1 parent born in Africa, Asia, Pacific Islands: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Chronic Problems/Significant Conditions: <input type="checkbox"/> None <input type="checkbox"/> See Problem List <input type="checkbox"/> DM <input type="checkbox"/> Dialysis <input type="checkbox"/> Heart Disease <input type="checkbox"/> HEP B <input type="checkbox"/> HEP C <input type="checkbox"/> HIV <input type="checkbox"/> Liver Disease <input type="checkbox"/> Seizures <input type="checkbox"/> Uses DME <input type="checkbox"/> ≥ 2 ER visits in 12 months <input type="checkbox"/> Other: _____	
Current Medications/Vitamins: <input type="checkbox"/> See Medication List	
Interval History	
Dental Home	Dental visit within past 12 months: <input type="checkbox"/> Yes <input type="checkbox"/> No Drinks fluoridated water or takes supplements: <input type="checkbox"/> Yes <input type="checkbox"/> No Fluoride varnish applied in last 6 months: <input type="checkbox"/> Yes <input type="checkbox"/> No
Diet / Nutrition	<input type="checkbox"/> Regular <input type="checkbox"/> Iron-rich foods <input type="checkbox"/> Other: _____
Elimination	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Has WIC	<input type="checkbox"/> Yes <input type="checkbox"/> No
Physical Activity	<input type="checkbox"/> Inactive (little or none) <input type="checkbox"/> Some (< 30 min/day) <input type="checkbox"/> Active (> 30 min/day)
Sleep	<input type="checkbox"/> Regular <input type="checkbox"/> Sleep regression <input type="checkbox"/> Nighttime fears
Vaccines Up to Date	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> See CAIR
Family History	<input type="checkbox"/> Unremarkable <input type="checkbox"/> Diabetes
<input type="checkbox"/> Heart disease / HTN	<input type="checkbox"/> Lives/lived with someone HBV+ <input type="checkbox"/> Born to HBV+ parents
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Cancer <input type="checkbox"/> Family Hx of unexpected or sudden death < 50 yrs
<input type="checkbox"/> Anemia	<input type="checkbox"/> Other: _____
Dyadic Behavioral / Social Determinants of Health (SDOH)	<input type="checkbox"/> WNL - Stable relationships w/ social/emotional support <input type="checkbox"/> Changes in family since last visit (move, job, death) <input type="checkbox"/> Problems with housing, food, employment <input type="checkbox"/> Family stressors (mental illness, drugs, violence/abuse)
Lives with	<input type="checkbox"/> 1 Parent <input type="checkbox"/> 2 Parents <input type="checkbox"/> Other: _____

Name: _____ DOB: _____ MR#: _____

AAP Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/Orders/AG)
Adverse Childhood Experiences	<input type="checkbox"/> PEARLS, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Blood Lead Test Test at 12 months and Educate at each well visit	<input type="checkbox"/> Lead Assessment, <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Dental (cavities, no dental home)	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Dyadic Behavioral / SDOH	<input type="checkbox"/> SDOH, <input type="checkbox"/> PEARLS, <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B	<input type="checkbox"/> CDC HEP Risk, <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco Use / Exposure	<input type="checkbox"/> SHA, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis Exposure	<input type="checkbox"/> TB Risk Assessment, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Growth and Development			
<input type="checkbox"/> Walks alone well	<input type="checkbox"/> Three-word vocabulary	<input type="checkbox"/> Stacks two-block tower	
<input type="checkbox"/> Stoops and recovers	<input type="checkbox"/> Plays pat-a-cake	<input type="checkbox"/> Says "mama" or "dada"	
<input type="checkbox"/> Takes lids off containers	<input type="checkbox"/> Feeds self	<input type="checkbox"/> Scribbles	
Physical Examination WNL			
General appearance	Well-nourished & developed No abuse/neglect evident	<input type="checkbox"/>	
Head	Symmetrical, A.F. open _____ cm	<input type="checkbox"/>	
Eyes	PERRLA, conjunctivae & sclerae clear Red reflexes present, No strabismus Appears to see	<input type="checkbox"/>	
Ears	Canals clear, TMs normal Appears to hear	<input type="checkbox"/>	
Nose	Passages clear, MM pink, no lesions	<input type="checkbox"/>	
Teeth	No visible cavities, grossly normal	<input type="checkbox"/>	
Mouth / Pharynx	Oral mucosa pink, no lesions	<input type="checkbox"/>	
Neck	Supple, no masses, thyroid not enlarged	<input type="checkbox"/>	
Chest / Breast	Symmetrical, no masses	<input type="checkbox"/>	
Heart	No organic murmurs, regular rhythm	<input type="checkbox"/>	
Lungs	Clear to auscultation bilaterally	<input type="checkbox"/>	
Abdomen	Soft, no masses, liver & spleen normal	<input type="checkbox"/>	
Genitalia	Grossly normal	<input type="checkbox"/>	
Male	Circ / uncircumcised, testes in scrotum	<input type="checkbox"/>	
Female	No lesions, normal external appearance	<input type="checkbox"/>	
Hips	Good abduction	<input type="checkbox"/>	
Femoral pulses	Normal	<input type="checkbox"/>	
Extremities	No deformities, full ROM	<input type="checkbox"/>	
Skin	Clear, no significant lesions	<input type="checkbox"/>	
Neurologic	Alert, no gross sensory or motor deficit	<input type="checkbox"/>	

Comprehensive Health Assessment

Subjective / Objective		
Assessment		
Plan		
Referrals		
<input type="checkbox"/> WIC	<input type="checkbox"/> Optometrist / Ophthalmologist	<input type="checkbox"/> Audiologist
<input type="checkbox"/> Dentist	<input type="checkbox"/> Dietician / Nutritionist	<input type="checkbox"/> Pulmonologist
<input type="checkbox"/> CA Children's Services (CCS)	<input type="checkbox"/> Regional Center	<input type="checkbox"/> Early Start or Local Education Agency
<input type="checkbox"/> Other:		
Orders		
<input type="checkbox"/> COVID 19 vaccine	<input type="checkbox"/> Meningococcal (if high risk)	<input type="checkbox"/> CBC / Basic metabolic panel
<input type="checkbox"/> DTaP	<input type="checkbox"/> MMR	<input type="checkbox"/> Hct / Hgb (at 12 months)
<input type="checkbox"/> Hep A vaccine	<input type="checkbox"/> PCV	<input type="checkbox"/> Lipid panel (if high risk)
<input type="checkbox"/> Hep B vaccine	<input type="checkbox"/> Varicella	<input type="checkbox"/> PPD skin test <input type="checkbox"/> QFT
<input type="checkbox"/> Hib	<input type="checkbox"/> Hep B Panel (if high risk)	<input type="checkbox"/> CXR <input type="checkbox"/> Urinalysis
<input type="checkbox"/> Influenza vaccine	<input type="checkbox"/> Blood Lead (at 12 months)	<input type="checkbox"/> ECG <input type="checkbox"/> COVID 19 test
<input type="checkbox"/> IPV	<input type="checkbox"/> Rx Fluoride drops / chewable tabs (0.25 mg QD)	<input type="checkbox"/> Fluoride varnish application
<input type="checkbox"/> Other:		

Name: _____ DOB: _____ MR#: _____

Anticipatory Guidance (AG) / Education (✓ if discussed)		
Health education preference: <input type="checkbox"/> Verbal <input type="checkbox"/> Visual <input type="checkbox"/> Multimedia <input type="checkbox"/> Other:		
Diet, Nutrition & Exercise		
<input type="checkbox"/> Relaxed atmosphere / Avoid rushing while eating	<input type="checkbox"/> Vegetables, fruits	<input type="checkbox"/> Table food
<input type="checkbox"/> Whole grains / iron-rich foods	<input type="checkbox"/> Encourage solids	<input type="checkbox"/> Using cup
<input type="checkbox"/> Physical activity / exercise	<input type="checkbox"/> Healthy food choices	<input type="checkbox"/> No bottles in bed
Accident Prevention & Guidance		
<input type="checkbox"/> Lead poisoning prevention	<input type="checkbox"/> Rear facing toddler car seat	<input type="checkbox"/> Feeding self
<input type="checkbox"/> Routine dental care	<input type="checkbox"/> Choking hazards	<input type="checkbox"/> Simple games
<input type="checkbox"/> Brush teeth with fluoride toothpaste	<input type="checkbox"/> Storage of drugs / toxic chemicals	<input type="checkbox"/> Temper tantrum
<input type="checkbox"/> Fluoride varnish treatment	<input type="checkbox"/> Matches / burns	<input type="checkbox"/> Family play
<input type="checkbox"/> Family support, social interaction & communication	<input type="checkbox"/> Violence prevention, gun safety	<input type="checkbox"/> Mindful of daily movements
<input type="checkbox"/> Caution with strangers	<input type="checkbox"/> Poison control phone number	<input type="checkbox"/> Treatment of minor cuts
<input type="checkbox"/> Skin cancer prevention	<input type="checkbox"/> Smoke detector	<input type="checkbox"/> Limit screen time
<input type="checkbox"/> Falls	<input type="checkbox"/> Hot water temp < 120° F	<input type="checkbox"/> Bedtime
<input type="checkbox"/> Effects of passive smoking	<input type="checkbox"/> Drowning / pool fence	<input type="checkbox"/> Toileting habits / training
Next Appointment		
<input type="checkbox"/> In 3 Months	<input type="checkbox"/> RTC PRN	<input type="checkbox"/> Other:

Documentation Reminders		
<input type="checkbox"/> Screening tools (TB, HEP B, etc.) are completed, dated, & reviewed by provider	<input type="checkbox"/> Length, Weight & Head Circumference measurements plotted in WHO growth chart	<input type="checkbox"/> Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date
Provider Signature	Title	Date

Notes (include date, time, signature, and title on all entries)
<input type="checkbox"/> Member/parent refused the following screening/orders:

Comprehensive Health Assessment

16 to 23 Months Old	Actual Age: _____ Date: _____
Sex at Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female
Accompanied by	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other: _____
Parent's Primary Language	_____
Interpreter Requested	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused Name of Interpreter: _____
Intake	(See WHO Growth Chart) Vital Signs
Head Circumference	Temp _____
Length	Pulse _____
Weight	Resp _____
Allergies / Reaction	_____
Pain	Location: _____ Scale: 0 1 2 3 4 5 6 7 8 9 10
Cultural Needs (e.g., cultural background/traditions, religious practices, dietary preference/restrictions, and healthcare beliefs): <input type="checkbox"/> Unremarkable	
Birth Weight: _____ Birth Length: _____ Gestational Age: _____ Delivery: <input type="checkbox"/> Vaginal <input type="checkbox"/> C-section Complications: <input type="checkbox"/> Yes <input type="checkbox"/> No Country of Birth: <input type="checkbox"/> US <input type="checkbox"/> Other: _____ At least 1 parent born in Africa, Asia, Pacific Islands: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Chronic Problems/Significant Conditions: <input type="checkbox"/> None <input type="checkbox"/> See Problem List <input type="checkbox"/> DM <input type="checkbox"/> Dialysis <input type="checkbox"/> Heart Disease <input type="checkbox"/> HEP B <input type="checkbox"/> HEP C <input type="checkbox"/> HIV <input type="checkbox"/> Liver Disease <input type="checkbox"/> Seizures <input type="checkbox"/> Uses DME <input type="checkbox"/> ≥ 2 ER visits in 12 months <input type="checkbox"/> Other: _____	
Current Medications/Vitamins: <input type="checkbox"/> See Medication List	
Interval History	
Dental Home	Dental visit within past 12 months: <input type="checkbox"/> Yes <input type="checkbox"/> No Drinks fluoridated water or takes supplements: <input type="checkbox"/> Yes <input type="checkbox"/> No Fluoride varnish applied in last 6 months: <input type="checkbox"/> Yes <input type="checkbox"/> No
Diet / Nutrition	<input type="checkbox"/> Regular <input type="checkbox"/> Iron-rich foods <input type="checkbox"/> Other: _____
Elimination	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Has WIC	<input type="checkbox"/> Yes <input type="checkbox"/> No
Physical Activity	<input type="checkbox"/> Inactive (little or none) <input type="checkbox"/> Some (< 30 min/day) <input type="checkbox"/> Active (> 30 min/day)
Sleep	<input type="checkbox"/> Regular <input type="checkbox"/> Sleep regression <input type="checkbox"/> Nighttime fears
Vaccines Up to Date	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> See CAIR
Family History	<input type="checkbox"/> Unremarkable <input type="checkbox"/> Diabetes
<input type="checkbox"/> Heart disease / HTN	<input type="checkbox"/> Lives/lived with someone HBV+ <input type="checkbox"/> Asthma
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Cancer <input type="checkbox"/> Family Hx of unexpected or sudden death < 50 yrs
<input type="checkbox"/> Anemia	<input type="checkbox"/> Other: _____
Dyadic Behavioral / Social Determinants of Health (SDOH)	<input type="checkbox"/> WNL - Stable relationships w/ social/emotional support <input type="checkbox"/> Changes in family since last visit (move, job, death) <input type="checkbox"/> Problems with housing, food, employment <input type="checkbox"/> Family stressors (mental illness, drugs, violence/abuse)
Lives with	<input type="checkbox"/> 1 Parent <input type="checkbox"/> 2 Parents <input type="checkbox"/> Other: _____

Name: _____

DOB: _____

MR#: _____

AAP Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/Orders/AG)
Adverse Childhood Experiences	<input type="checkbox"/> PEARLS , <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Autism Disorder (At 18 months) Score: ____	<input type="checkbox"/> SWYC , <input type="checkbox"/> M-CHAT , <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Blood Lead Education (At each Well Visit)	<input type="checkbox"/> Lead Assessment , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Dental (cavities, no dental home)	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Developmental Disorder (At 18 months) Score: ____	<input type="checkbox"/> ASQ-3 , <input type="checkbox"/> SWYC , <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Dyadic Behavioral / SDOH	<input type="checkbox"/> SDOH , <input type="checkbox"/> PEARLS , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B	<input type="checkbox"/> CDC HEP Risk , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco Use / Exposure	<input type="checkbox"/> SHA , <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis Exposure	<input type="checkbox"/> TB Risk Assessment , <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Growth and Development			
<input type="checkbox"/> Walks alone fast	<input type="checkbox"/> 7 to 20-word vocabulary	<input type="checkbox"/> Stacks three-block tower	
<input type="checkbox"/> Climbs	<input type="checkbox"/> Names 5 body parts	<input type="checkbox"/> Says "mama" or "dada"	
<input type="checkbox"/> Kicks a ball	<input type="checkbox"/> Indicates wants by pointing and pulling	<input type="checkbox"/> Sips from cup, a little spillage	
Physical Examination			WNL
General appearance	Well-nourished & developed No abuse/neglect evident	<input type="checkbox"/>	
Head	Symmetrical, A.F. open ____cm	<input type="checkbox"/>	
Eyes	PERRLA, conjunctivae & sclerae clear Red reflexes present, No strabismus Appears to see	<input type="checkbox"/>	
Ears	Canals clear, TMs normal Appears to hear	<input type="checkbox"/>	
Nose	Passages clear, MM pink, no lesions	<input type="checkbox"/>	
Teeth	No visible cavities & grossly normal	<input type="checkbox"/>	
Mouth / Pharynx	Oral mucosa pink, no lesions	<input type="checkbox"/>	
Neck	Supple, no masses, thyroid not enlarged	<input type="checkbox"/>	
Chest / Breast	Symmetrical, no masses	<input type="checkbox"/>	
Heart	No organic murmurs, regular rhythm	<input type="checkbox"/>	
Lungs	Clear to auscultation bilaterally	<input type="checkbox"/>	
Abdomen	Soft, no masses, liver & spleen normal	<input type="checkbox"/>	
Genitalia	Grossly normal	<input type="checkbox"/>	
Male	Circ / uncircumcised, testes in scrotum	<input type="checkbox"/>	
Female	No lesions, normal external appearance	<input type="checkbox"/>	
Hips	Good abduction, leg length equal	<input type="checkbox"/>	
Femoral pulses	Normal	<input type="checkbox"/>	
Extremities	No deformities, full ROM	<input type="checkbox"/>	
Skin	Clear, no significant lesions	<input type="checkbox"/>	

Comprehensive Health Assessment

Neurologic	Alert, no gross sensory or motor deficit	<input type="checkbox"/>
Subjective / Objective		
Assessment		
Plan		
Referrals		
<input type="checkbox"/> WIC	<input type="checkbox"/> Optometrist / Ophthalmologist	<input type="checkbox"/> Audiologist
<input type="checkbox"/> Dentist	<input type="checkbox"/> Dietician / Nutritionist	<input type="checkbox"/> Pulmonologist
<input type="checkbox"/> CA Children's Services (CCS)	<input type="checkbox"/> Regional Center	<input type="checkbox"/> Early Start or Local Education Agency
<input type="checkbox"/> Other:		
Orders		
<input type="checkbox"/> COVID 19 vaccine	<input type="checkbox"/> Meningococcal (if high risk)	<input type="checkbox"/> CBC / Basic metabolic panel
<input type="checkbox"/> DTaP (if not up to date)	<input type="checkbox"/> MMR (if not up to date)	<input type="checkbox"/> Hct / Hgb (if high risk)
<input type="checkbox"/> Hep A vaccine (if not up to date)	<input type="checkbox"/> PPSV (if high risk)	<input type="checkbox"/> Lipid panel (if high risk)
<input type="checkbox"/> Hep B vaccine (if not up to date)	<input type="checkbox"/> Varicella (2 nd Dose)	<input type="checkbox"/> PPD skin test
<input type="checkbox"/> Hib (if not up to date)	<input type="checkbox"/> Blood Lead	<input type="checkbox"/> QFT
<input type="checkbox"/> Influenza vaccine	<input type="checkbox"/> CXR	<input type="checkbox"/> ECG
<input type="checkbox"/> IPV (if not up to date)	<input type="checkbox"/> Urinalysis	<input type="checkbox"/> COVID 19 test
<input type="checkbox"/> Other:	<input type="checkbox"/> Hep B Panel (if high risk)	<input type="checkbox"/> ECG
	<input type="checkbox"/> Rx Fluoride drops / chewable tabs (0.25 mg QD)	<input type="checkbox"/> Fluoride varnish application

Name: _____ DOB: _____ MR#: _____

Anticipatory Guidance (AG) / Education (✓ if discussed)		
Health education preference: <input type="checkbox"/> Verbal <input type="checkbox"/> Visual <input type="checkbox"/> Multimedia <input type="checkbox"/> Other:		
Diet, Nutrition & Exercise		
<input type="checkbox"/> Relaxed atmosphere / Avoid rushing while eating	<input type="checkbox"/> Vegetables, fruits	<input type="checkbox"/> Caloric balance
<input type="checkbox"/> Whole grains / iron-rich foods	<input type="checkbox"/> Switch to low-fat milk	<input type="checkbox"/> Limit candy, chips & ice cream
<input type="checkbox"/> Physical activity / exercise	<input type="checkbox"/> Regular balanced meal with snacks	<input type="checkbox"/> No bottles
Accident Prevention & Guidance		
<input type="checkbox"/> Lead poisoning prevention	<input type="checkbox"/> Rear facing toddler car seat	<input type="checkbox"/> Independence
<input type="checkbox"/> Routine dental care	<input type="checkbox"/> Safety helmet	<input type="checkbox"/> Make-believe / role play
<input type="checkbox"/> Brush teeth with fluoride toothpaste	<input type="checkbox"/> Storage of drugs / toxic chemicals	<input type="checkbox"/> Dressing self
<input type="checkbox"/> Fluoride varnish treatment	<input type="checkbox"/> Matches / burns	<input type="checkbox"/> Reading together
<input type="checkbox"/> Family support, social interaction & communication	<input type="checkbox"/> Violence prevention, gun safety	<input type="checkbox"/> Mindful of daily movements
<input type="checkbox"/> Caution with strangers	<input type="checkbox"/> Poison control phone number	<input type="checkbox"/> Parallel peer play
<input type="checkbox"/> Skin cancer prevention	<input type="checkbox"/> Smoke detector	<input type="checkbox"/> Limit screen time
<input type="checkbox"/> Falls	<input type="checkbox"/> Hot water temp < 120° F	<input type="checkbox"/> Bedtime
<input type="checkbox"/> Effects of passive smoking	<input type="checkbox"/> Drowning / pool fence	<input type="checkbox"/> Toileting habits / training
Next Appointment		
<input type="checkbox"/> At 2 Years Old	<input type="checkbox"/> RTC PRN	<input type="checkbox"/> Other:

Documentation Reminders		
<input type="checkbox"/> Screening tools (TB, Autism, Developmental D/O, HEP B, etc.) are completed, dated, & reviewed by provider	<input type="checkbox"/> Length, Weight & Head Circumference measurements plotted in WHO growth chart	<input type="checkbox"/> Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date
Provider Signature	Title	Date

Notes (include date, time, signature, and title on all entries)
<input type="checkbox"/> Member/parent refused the following screening/orders:

Comprehensive Health Assessment

2 Years Old	Actual Age: _____ Date: _____
Sex at Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female
Accompanied by	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other: _____
Parent's Primary Language	_____
Interpreter Requested	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused Name of Interpreter: _____
Intake	(See CDC Growth Chart) Vital Signs
Allergies / Reaction	Temp _____
Height	Pulse _____
Weight	Resp _____
BMI Value	BMI % _____
Pain	Location: _____ Scale: 0 1 2 3 4 5 6 7 8 9 10
Cultural Needs (e.g., cultural background/traditions, religious practices, dietary preference/restrictions, and healthcare beliefs): <input type="checkbox"/> Unremarkable	
Birth Weight: _____ Birth Length: _____ Gestational Age: _____ Delivery: <input type="checkbox"/> Vaginal <input type="checkbox"/> C-section Complications: <input type="checkbox"/> Yes <input type="checkbox"/> No Country of Birth: <input type="checkbox"/> US <input type="checkbox"/> Other: _____ At least 1 parent born in Africa, Asia, Pacific Islands: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Chronic Problems/Significant Conditions: <input type="checkbox"/> None <input type="checkbox"/> See Problem List <input type="checkbox"/> DM <input type="checkbox"/> Dialysis <input type="checkbox"/> Heart Disease <input type="checkbox"/> HEP B <input type="checkbox"/> HEP C <input type="checkbox"/> HIV <input type="checkbox"/> Liver Disease <input type="checkbox"/> Seizures <input type="checkbox"/> Uses DME <input type="checkbox"/> ≥ 2 ER visits in 12 months <input type="checkbox"/> Other: _____	
Current Medications/Vitamins: <input type="checkbox"/> See Medication List	
Interval History	
Dental Home	Dental visit within past 12 months: <input type="checkbox"/> Yes <input type="checkbox"/> No Drinks fluoridated water or takes supplements: <input type="checkbox"/> Yes <input type="checkbox"/> No Fluoride varnish applied in last 6 months: <input type="checkbox"/> Yes <input type="checkbox"/> No
Diet / Nutrition	<input type="checkbox"/> Regular <input type="checkbox"/> Iron-rich foods <input type="checkbox"/> Other: _____
Appetite	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
Elimination	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Has WIC	<input type="checkbox"/> Yes <input type="checkbox"/> No
Physical Activity	<input type="checkbox"/> Inactive (little or none) <input type="checkbox"/> Some (< 2 ½ hrs/week) <input type="checkbox"/> Active (> 60 min/day)
Sleep Pattern	<input type="checkbox"/> Regular <input type="checkbox"/> Sleep regression <input type="checkbox"/> Nighttime fears
Vaccines Up to Date	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> See CAIR
Family History	<input type="checkbox"/> Unremarkable <input type="checkbox"/> Diabetes
<input type="checkbox"/> Heart disease / HTN	<input type="checkbox"/> Lives/lived with someone HBV+ <input type="checkbox"/> Asthma
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Cancer <input type="checkbox"/> Family Hx of unexpected or sudden death < 50 yrs
<input type="checkbox"/> Anemia	<input type="checkbox"/> Other: _____

Name: _____

DOB: _____

MR#: _____

Dyadic Behavioral / Social Determinants of Health (SDOH)	<input type="checkbox"/> WNL - Stable relationships w/ social/emotional support <input type="checkbox"/> Changes in family since last visit (move, job, death) <input type="checkbox"/> Problems with housing, food, employment <input type="checkbox"/> Family stressors (mental illness, drugs, violence/abuse)		
Lives with	<input type="checkbox"/> 1 Parent <input type="checkbox"/> 2 Parents <input type="checkbox"/> Other: _____		
AAP Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/Orders/AG)
Adverse Childhood Experiences	<input type="checkbox"/> PEARLS, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Autism Disorder Score: _____	<input type="checkbox"/> ASQ-3, <input type="checkbox"/> SWYC, <input type="checkbox"/> M-CHAT, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Blood Lead Test Test at 24 months and Educate at each well visit	<input type="checkbox"/> Lead Assessment, <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Dental (cavities, no dental home)	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Developmental Disorder Score: _____	<input type="checkbox"/> ASQ-3, <input type="checkbox"/> SWYC, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Dyadic Behavioral / SDOH	<input type="checkbox"/> SDOH, <input type="checkbox"/> PEARLS, <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Dyslipidemia	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B	<input type="checkbox"/> CDC HEP Risk, <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco Use / Exposure	<input type="checkbox"/> SHA, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis Exposure	<input type="checkbox"/> TB Risk Assessment, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Growth and Development			
<input type="checkbox"/> Runs well, walks up and down	<input type="checkbox"/> Identifies 5 body parts	<input type="checkbox"/> Helps around the house	
<input type="checkbox"/> Jumps off the ground with both feet	<input type="checkbox"/> Plays hide and seek	<input type="checkbox"/> Stacks three-block tower	
<input type="checkbox"/> Puts 2 or more words together	<input type="checkbox"/> Kicks and throws a ball	<input type="checkbox"/> Handles spoon well	
<input type="checkbox"/> 7 to 20-word vocabulary	<input type="checkbox"/> Name at least 1 color	<input type="checkbox"/> Puts on simple clothes	
Physical Examination			WNL
General appearance	Well-nourished & developed No abuse/neglect evident	<input type="checkbox"/>	
Head	Symmetrical, A.F. closed	<input type="checkbox"/>	
Eyes	PERRLA, conjunctivae & sclerae clear Red reflexes present, No strabismus Appears to see	<input type="checkbox"/>	
Ears	Canals clear, TMs normal Appears to hear	<input type="checkbox"/>	
Nose	Passages clear, MM pink, no lesions	<input type="checkbox"/>	
Teeth	No visible cavities, grossly normal	<input type="checkbox"/>	
Mouth / Pharynx	Oral mucosa pink, no lesions	<input type="checkbox"/>	
Neck	Supple, no masses, thyroid not enlarged	<input type="checkbox"/>	
Chest / Breast	Symmetrical, no masses	<input type="checkbox"/>	
Heart	No organic murmurs, regular rhythm	<input type="checkbox"/>	
Lungs	Clear to auscultation bilaterally	<input type="checkbox"/>	
Abdomen	Soft, no masses, liver & spleen normal	<input type="checkbox"/>	

Comprehensive Health Assessment

Genitalia	Grossly normal	<input type="checkbox"/>
Male	Circ / uncircumcised, testes in scrotum	<input type="checkbox"/>
Female	No lesions, normal external appearance	<input type="checkbox"/>
Hips	Good abduction	<input type="checkbox"/>
Femoral pulses	Normal	<input type="checkbox"/>
Extremities	No deformities, full ROM	<input type="checkbox"/>
Lymph nodes	Not enlarged	<input type="checkbox"/>
Back	No scoliosis	<input type="checkbox"/>
Skin	Clear, no significant lesions	<input type="checkbox"/>
Neurologic	Alert, no gross sensory or motor deficit	<input type="checkbox"/>
Subjective / Objective		
Assessment		
Plan		
Referrals		
<input type="checkbox"/> WIC	<input type="checkbox"/> Optometrist / Ophthalmologist	<input type="checkbox"/> Audiologist
<input type="checkbox"/> Dentist	<input type="checkbox"/> Dietician / Nutritionist	<input type="checkbox"/> Pulmonologist
<input type="checkbox"/> CA Children's Services (CCS)	<input type="checkbox"/> Regional Center	<input type="checkbox"/> Early Start or Local Education Agency
<input type="checkbox"/> Other:		
Orders		
<input type="checkbox"/> COVID 19 vaccine	<input type="checkbox"/> Meningococcal (if high risk)	<input type="checkbox"/> CBC / Basic metabolic panel
<input type="checkbox"/> DTaP (if not up to date)	<input type="checkbox"/> MMR (if not up to date)	<input type="checkbox"/> Hct / Hgb (if high risk)
<input type="checkbox"/> Hep A vaccine (if not up to date)	<input type="checkbox"/> PPSV (if high risk)	<input type="checkbox"/> Lipid panel (if high risk)
<input type="checkbox"/> Hep B vaccine (if not up to date)	<input type="checkbox"/> Varicella (2 nd Dose)	<input type="checkbox"/> PPD skin test <input type="checkbox"/> QFT
<input type="checkbox"/> Hib (if not up to date)	<input type="checkbox"/> Blood Lead (at 2 yrs old)	<input type="checkbox"/> CXR <input type="checkbox"/> Urinalysis
<input type="checkbox"/> Influenza vaccine	<input type="checkbox"/> Hep B Panel (if high risk)	<input type="checkbox"/> ECG <input type="checkbox"/> COVID 19 test
<input type="checkbox"/> IPV (if not up to date)	<input type="checkbox"/> Rx Fluoride drops / chewable tabs (0.25 mg QD)	<input type="checkbox"/> Fluoride varnish application
<input type="checkbox"/> Other:		

Name: _____ DOB: _____ MR#: _____

Anticipatory Guidance (AG) / Education (✓ if discussed)		
Health education preference: <input type="checkbox"/> Verbal <input type="checkbox"/> Visual <input type="checkbox"/> Multimedia <input type="checkbox"/> Other:		
Diet, Nutrition & Exercise		
<input type="checkbox"/> Weight control / obesity	<input type="checkbox"/> Vegetables, fruits	<input type="checkbox"/> Caloric balance
<input type="checkbox"/> Whole grains / iron-rich foods	<input type="checkbox"/> Switch to low-fat milk	<input type="checkbox"/> Limit candy, chips & ice cream
<input type="checkbox"/> Physical activity / exercise	<input type="checkbox"/> Regular balanced meal with snacks	<input type="checkbox"/> No bottles
Accident Prevention & Guidance		
<input type="checkbox"/> Lead poisoning prevention	<input type="checkbox"/> Seat belt / Toddler car seat	<input type="checkbox"/> Independence
<input type="checkbox"/> Routine dental care	<input type="checkbox"/> Safety helmet	<input type="checkbox"/> Make-believe / role play
<input type="checkbox"/> Brush teeth with fluoride toothpaste	<input type="checkbox"/> Storage of drugs / toxic chemicals	<input type="checkbox"/> Dressing self
<input type="checkbox"/> Fluoride varnish treatment	<input type="checkbox"/> Matches / burns	<input type="checkbox"/> Reading together
<input type="checkbox"/> Family support, social interaction & communication	<input type="checkbox"/> Violence prevention, gun safety	<input type="checkbox"/> Mindful of daily movements
<input type="checkbox"/> Caution with strangers	<input type="checkbox"/> Poison control phone number	<input type="checkbox"/> Parallel peer play
<input type="checkbox"/> Skin cancer prevention	<input type="checkbox"/> Smoke detector	<input type="checkbox"/> Limit screen time
<input type="checkbox"/> Falls	<input type="checkbox"/> Hot water temp < 120° F	<input type="checkbox"/> Bedtime
<input type="checkbox"/> Effects of passive smoking	<input type="checkbox"/> Drowning / pool fence	<input type="checkbox"/> Toileting habits / training
Next Appointment		
<input type="checkbox"/> At 30 Months Old	<input type="checkbox"/> RTC PRN	<input type="checkbox"/> Other:

Documentation Reminders		
<input type="checkbox"/> Screening tools (TB, Autism, Developmental D/O, HEP B, etc.) are completed, dated, & reviewed by provider	<input type="checkbox"/> Height / Weight / BMI measurements plotted in CDC growth chart	<input type="checkbox"/> Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date
Provider Signature	Title	Date

Notes (include date, time, signature, and title on all entries)		
<input type="checkbox"/> Member/parent refused the following screening/orders:		

Comprehensive Health Assessment

30 Months Old	Actual Age: _____ Date: _____
Sex at Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female
Accompanied by	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other: _____
Parent's Primary Language	_____
Interpreter Requested	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused Name of Interpreter: _____
Intake	(See CDC Growth Chart) Vital Signs
Allergies / Reaction	Temp _____
Height	Pulse _____
Weight	Resp _____
BMI Value	BMI % _____
Pain	Location: _____ Scale: 0 1 2 3 4 5 6 7 8 9 10
Cultural Needs (e.g., cultural background/traditions, religious practices, dietary preference/restrictions, and healthcare beliefs): <input type="checkbox"/> Unremarkable	
Birth Weight: _____ Birth Length: _____ Gestational Age: _____ Delivery: <input type="checkbox"/> Vaginal <input type="checkbox"/> C-section Complications: <input type="checkbox"/> Yes <input type="checkbox"/> No Country of Birth: <input type="checkbox"/> US <input type="checkbox"/> Other: _____ At least 1 parent born in Africa, Asia, Pacific Islands: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Chronic Problems/Significant Conditions: <input type="checkbox"/> None <input type="checkbox"/> See Problem List <input type="checkbox"/> DM <input type="checkbox"/> Dialysis <input type="checkbox"/> Heart Disease <input type="checkbox"/> HEP B <input type="checkbox"/> HEP C <input type="checkbox"/> HIV <input type="checkbox"/> Liver Disease <input type="checkbox"/> Seizures <input type="checkbox"/> Uses DME <input type="checkbox"/> ≥ 2 ER visits in 12 months <input type="checkbox"/> Other: _____	
Current Medications/Vitamins: <input type="checkbox"/> See Medication List	
Interval History	
Dental Home	Dental visit within past 12 months: <input type="checkbox"/> Yes <input type="checkbox"/> No Drinks fluoridated water or takes supplements: <input type="checkbox"/> Yes <input type="checkbox"/> No Fluoride varnish applied in last 6 months: <input type="checkbox"/> Yes <input type="checkbox"/> No
Diet / Nutrition	<input type="checkbox"/> Regular <input type="checkbox"/> Iron-rich foods <input type="checkbox"/> Other: _____
Appetite	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
Elimination	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Has WIC	<input type="checkbox"/> Yes <input type="checkbox"/> No
Physical Activity	<input type="checkbox"/> Inactive (little or none) <input type="checkbox"/> Some (< 2 ½ hrs/week) <input type="checkbox"/> Active (> 60 min/day)
Sleep Pattern	<input type="checkbox"/> Regular <input type="checkbox"/> Sleep regression <input type="checkbox"/> Night time fears
Vaccines Up to Date	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> See CAIR
Family History	<input type="checkbox"/> Unremarkable <input type="checkbox"/> Diabetes
<input type="checkbox"/> Heart disease / HTN	<input type="checkbox"/> Lives/lived with someone HBV+ <input type="checkbox"/> Asthma
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Cancer <input type="checkbox"/> Family Hx of unexpected or sudden death < 50 yrs
<input type="checkbox"/> Anemia	<input type="checkbox"/> Other: _____

Name: _____ DOB: _____ MR#: _____

Dyadic Behavioral / Social Determinants of Health (SDOH)	<input type="checkbox"/> WNL - Stable relationships w/ social/emotional support <input type="checkbox"/> Changes in family since last visit (move, job, death) <input type="checkbox"/> Problems with housing, food, employment <input type="checkbox"/> Family stressors (mental illness, drugs, violence/abuse)		
Lives with	<input type="checkbox"/> 1 Parent <input type="checkbox"/> 2 Parents <input type="checkbox"/> Other: _____		
AAP Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/Orders/AG)
Adverse Childhood Experiences	<input type="checkbox"/> PEARLS , <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Blood Lead Education (At each Well Visit)	<input type="checkbox"/> Lead Assessment , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Dental (cavities, no dental home)	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Developmental Disorder Score: _____	<input type="checkbox"/> ASQ-3 , <input type="checkbox"/> SWYC , <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Dyadic Behavioral / SDOH	<input type="checkbox"/> SDOH , <input type="checkbox"/> PEARLS , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B	<input type="checkbox"/> CDC HEP Risk , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco Use / Exposure	<input type="checkbox"/> SHA , <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis Exposure	<input type="checkbox"/> TB Risk Assessment , <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Growth and Development			
<input type="checkbox"/> Balances on each foot, 1 second	<input type="checkbox"/> Eats independently	<input type="checkbox"/> Helps in dressing	
<input type="checkbox"/> Uses 3-word sentences	<input type="checkbox"/> Goes up stairs alternating feet	<input type="checkbox"/> Draws a single circle	
<input type="checkbox"/> Plays with other children	<input type="checkbox"/> Knows age, sex, first, & last name	<input type="checkbox"/> Cuts with scissors	
Physical Examination WNL			
General appearance	Well-nourished & developed No abuse/neglect evident		<input type="checkbox"/>
Head	Symmetrical, A.F. closed		<input type="checkbox"/>
Eyes	PERRLA, conjunctivae & sclerae clear Red reflexes present, No strabismus Appears to see		<input type="checkbox"/>
Ears	Canals clear, TMs normal Appears to hear		<input type="checkbox"/>
Nose	Passages clear, MM pink, no lesions		<input type="checkbox"/>
Teeth	No visible cavities, grossly normal		<input type="checkbox"/>
Mouth / Pharynx	Oral mucosa pink, no lesions		<input type="checkbox"/>
Neck	Supple, no masses, thyroid not enlarged		<input type="checkbox"/>
Chest / Breast	Symmetrical, no masses		<input type="checkbox"/>
Heart	No organic murmurs, regular rhythm		<input type="checkbox"/>
Lungs	Clear to auscultation bilaterally		<input type="checkbox"/>
Abdomen	Soft, no masses, liver & spleen normal		<input type="checkbox"/>
Genitalia	Grossly normal		<input type="checkbox"/>
Male	Circ / uncircumcised, testes in scrotum		<input type="checkbox"/>
Female	No lesions, normal external appearance		<input type="checkbox"/>
Hips	Good abduction		<input type="checkbox"/>

Comprehensive Health Assessment

Femoral pulses	Normal	<input type="checkbox"/>
Extremities	No deformities, full ROM	<input type="checkbox"/>
Skin	Clear, no significant lesions	<input type="checkbox"/>
Neurologic	Alert, no gross sensory or motor deficit	<input type="checkbox"/>
Subjective / Objective		
Assessment		
Plan		
Referrals		
<input type="checkbox"/> WIC	<input type="checkbox"/> Optometrist / Ophthalmologist	<input type="checkbox"/> Audiologist
<input type="checkbox"/> Dentist	<input type="checkbox"/> Dietician / Nutritionist	<input type="checkbox"/> Pulmonologist
<input type="checkbox"/> CA Children's Services (CCS)	<input type="checkbox"/> Regional Center	<input type="checkbox"/> Early Start or Local Education Agency
<input type="checkbox"/> Other:		
Orders		
<input type="checkbox"/> COVID 19 vaccine	<input type="checkbox"/> MMR	<input type="checkbox"/> CBC / Basic metabolic panel
<input type="checkbox"/> DTaP	<input type="checkbox"/> PPSV	<input type="checkbox"/> Hct / Hgb (if high risk)
<input type="checkbox"/> Hep A vaccine (if not up to date)	<input type="checkbox"/> PPSV (if high risk)	<input type="checkbox"/> Lipid panel (if high risk)
<input type="checkbox"/> Hep B vaccine (if not up to date)	<input type="checkbox"/> Varicella (2 nd Dose)	<input type="checkbox"/> PPD skin test <input type="checkbox"/> QFT
<input type="checkbox"/> IPV	<input type="checkbox"/> Blood Lead (if not in chart)	<input type="checkbox"/> CXR <input type="checkbox"/> Urinalysis
<input type="checkbox"/> Influenza vaccine	<input type="checkbox"/> Hep B Panel (if high risk)	<input type="checkbox"/> ECG <input type="checkbox"/> COVID 19 test
<input type="checkbox"/> Meningococcal (if high risk)	<input type="checkbox"/> Rx Fluoride drops / chewable tabs (0.25 mg QD)	<input type="checkbox"/> Fluoride varnish application
<input type="checkbox"/> Other:		

Name: _____ DOB: _____ MR#: _____

Anticipatory Guidance (AG) / Education (✓ if discussed)		
Health education preference: <input type="checkbox"/> Verbal <input type="checkbox"/> Visual <input type="checkbox"/> Multimedia <input type="checkbox"/> Other:		
Diet, Nutrition & Exercise		
<input type="checkbox"/> Weight control / obesity	<input type="checkbox"/> Vegetables, fruits	<input type="checkbox"/> Meal socialization
<input type="checkbox"/> Whole grains / iron-rich foods	<input type="checkbox"/> Limit fatty, sugary & salty foods	<input type="checkbox"/> Limit candy, chips & ice cream
<input type="checkbox"/> Physical activity / exercise	<input type="checkbox"/> Regular balanced meal with snacks	<input type="checkbox"/> No bottles
Accident Prevention & Guidance		
<input type="checkbox"/> Lead poisoning prevention	<input type="checkbox"/> Seat belt / Toddler car seat	<input type="checkbox"/> Independence
<input type="checkbox"/> Routine dental care	<input type="checkbox"/> Safety helmet	<input type="checkbox"/> Make-believe / role play
<input type="checkbox"/> Brush teeth with fluoride toothpaste	<input type="checkbox"/> Storage of drugs / toxic chemicals	<input type="checkbox"/> Dressing self
<input type="checkbox"/> Fluoride varnish treatment	<input type="checkbox"/> Matches / burns	<input type="checkbox"/> Reading together / school readiness
<input type="checkbox"/> Family support, social interaction & communication	<input type="checkbox"/> Violence prevention, gun safety	<input type="checkbox"/> Knows name, address, & phone number
<input type="checkbox"/> Caution with strangers	<input type="checkbox"/> Poison control phone number	<input type="checkbox"/> Plays with other children
<input type="checkbox"/> Skin cancer prevention	<input type="checkbox"/> Smoke detector	<input type="checkbox"/> Limit screen time
<input type="checkbox"/> Falls	<input type="checkbox"/> Hot water temp < 120° F	<input type="checkbox"/> Bedtime
<input type="checkbox"/> Effects of passive smoking	<input type="checkbox"/> Drowning / pool fence	<input type="checkbox"/> Toileting habits
Next Appointment		
<input type="checkbox"/> At 3 Years Old	<input type="checkbox"/> RTC PRN	<input type="checkbox"/> Other:

Documentation Reminders		
<input type="checkbox"/> Screening tools (TB, Developmental D/O, HEP B, etc.) are completed, dated, & reviewed by provider	<input type="checkbox"/> Height / Weight / BMI measurements plotted in CDC growth chart	<input type="checkbox"/> Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date
Provider Signature	Title	Date

Notes (include date, time, signature, and title on all entries)
<input type="checkbox"/> Member/parent refused the following screening/orders:

Comprehensive Health Assessment

3 Years Old	Actual Age: _____ Date: _____
Sex at Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female
Accompanied by	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other: _____
Parent's Primary Language	_____
Interpreter Requested	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused Name of Interpreter: _____
Intake	(See CDC Growth Chart) Vital Signs
Height	Temp _____
Weight	BP _____
BMI Value	Pulse _____
BMI %	Resp _____
Allergies / Reaction	_____
Pain	Location: _____ Scale: 0 1 2 3 4 5 6 7 8 9 10
Hearing Screening	<input type="checkbox"/> Responded at ≤ 25 dB at 1000-4000 frequencies in both ears <input type="checkbox"/> Non coop
Vision Screening	OD: _____ OS: _____ OU: _____ <input type="checkbox"/> Non coop
Cultural Needs (e.g., cultural background/traditions, religious practices, dietary preference/restrictions, and healthcare beliefs):	<input type="checkbox"/> Unremarkable
Birth Weight: _____ Birth Length: _____ Gestational Age: _____ Delivery: <input type="checkbox"/> Vaginal <input type="checkbox"/> C-section Complications: <input type="checkbox"/> Yes <input type="checkbox"/> No Country of Birth: <input type="checkbox"/> US <input type="checkbox"/> Other: _____ At least 1 parent born in Africa, Asia, Pacific Islands: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Chronic Problems/Significant Conditions: <input type="checkbox"/> None <input type="checkbox"/> See Problem List <input type="checkbox"/> DM <input type="checkbox"/> Dialysis <input type="checkbox"/> Heart Disease <input type="checkbox"/> HEP B <input type="checkbox"/> HEP C <input type="checkbox"/> HIV <input type="checkbox"/> Liver Disease <input type="checkbox"/> Seizures <input type="checkbox"/> Uses DME <input type="checkbox"/> ≥ 2 ER visits in 12 months <input type="checkbox"/> Other: _____	
Current Medications/Vitamins: <input type="checkbox"/> See Medication List	
Interval History	
Dental Home	Dental visit within past 12 months: <input type="checkbox"/> Yes <input type="checkbox"/> No Drinks fluoridated water or takes supplements: <input type="checkbox"/> Yes <input type="checkbox"/> No Fluoride varnish applied in last 6 months: <input type="checkbox"/> Yes <input type="checkbox"/> No
Diet / Nutrition	<input type="checkbox"/> Regular <input type="checkbox"/> Iron-rich foods <input type="checkbox"/> Other: _____
Appetite	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
Elimination	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Has WIC	<input type="checkbox"/> Yes <input type="checkbox"/> No
Physical Activity	<input type="checkbox"/> Inactive (little or none) <input type="checkbox"/> Some (< 2 ½ hrs/week) <input type="checkbox"/> Active (> 60 min/day)
Sleep Pattern	<input type="checkbox"/> Regular <input type="checkbox"/> Fatigue <input type="checkbox"/> Snoring <input type="checkbox"/> Enuresis
Vaccines Up to Date	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> See CAIR

Name: _____ DOB: _____ MR#: _____

Family History	<input type="checkbox"/> Unremarkable <input type="checkbox"/> Diabetes
<input type="checkbox"/> Heart disease / HTN	<input type="checkbox"/> Lives/lived with someone HBV+ <input type="checkbox"/> Asthma
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Cancer <input type="checkbox"/> Family Hx of unexpected or sudden death < 50 yrs
<input type="checkbox"/> Anemia	<input type="checkbox"/> Other: _____
Dyadic Behavioral / Social Determinants of Health (SDOH)	<input type="checkbox"/> WNL - Stable relationships w/ social/emotional support <input type="checkbox"/> Changes in family since last visit (move, job, death) <input type="checkbox"/> Problems with housing, food, employment <input type="checkbox"/> Family stressors (mental illness, drugs, violence/abuse)
Lives with	<input type="checkbox"/> 1 Parent <input type="checkbox"/> 2 Parents <input type="checkbox"/> Other: _____
AAP Risk Screener	Screening Tools Used Low Risk High Risk (see Plan/Orders/AG)
Adverse Childhood Experiences	<input type="checkbox"/> PEARLS , <input type="checkbox"/> Other: _____ <input type="checkbox"/> <input type="checkbox"/>
Anemia	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____ <input type="checkbox"/> <input type="checkbox"/>
Blood Lead Education (At each Well Visit)	<input type="checkbox"/> Lead Assessment , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____ <input type="checkbox"/> <input type="checkbox"/>
Dental (cavities, no dental home)	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____ <input type="checkbox"/> <input type="checkbox"/>
Dyadic Behavioral / SDOH	<input type="checkbox"/> SDOH , <input type="checkbox"/> PEARLS , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____ <input type="checkbox"/> <input type="checkbox"/>
Hepatitis B	<input type="checkbox"/> CDC HEP Risk , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____ <input type="checkbox"/> <input type="checkbox"/>
Tobacco Use / Exposure	<input type="checkbox"/> SHA , <input type="checkbox"/> Other: _____ <input type="checkbox"/> <input type="checkbox"/>
Tuberculosis Exposure	<input type="checkbox"/> TB Risk Assessment , <input type="checkbox"/> Other: _____ <input type="checkbox"/> <input type="checkbox"/>
Growth and Development	
<input type="checkbox"/> Balances on each foot, 1 second	<input type="checkbox"/> Eats independently <input type="checkbox"/> Helps in dressing
<input type="checkbox"/> Uses 3-word sentences	<input type="checkbox"/> Goes up stairs alternating feet <input type="checkbox"/> Draws a single circle
<input type="checkbox"/> Plays with several children	<input type="checkbox"/> Knows age, sex, first, & last name <input type="checkbox"/> Cuts with scissors
Physical Examination WNL	
General appearance	Well-nourished & developed No abuse/neglect evident <input type="checkbox"/>
Head	Symmetrical, A.F. closed <input type="checkbox"/>
Eyes	PERRLA, conjunctivae & sclerae clear Red reflexes present, No strabismus Appears to see <input type="checkbox"/>
Ears	Canals clear, TMs normal Appears to hear <input type="checkbox"/>
Nose	Passages clear, MM pink, no lesions <input type="checkbox"/>
Teeth	No visible cavities, grossly normal <input type="checkbox"/>
Mouth / Pharynx	Oral mucosa pink, no lesions <input type="checkbox"/>
Neck	Supple, no masses, thyroid not enlarged <input type="checkbox"/>
Chest / Breast	Symmetrical, no masses <input type="checkbox"/>
Heart	No organic murmurs, regular rhythm <input type="checkbox"/>
Lungs	Clear to auscultation bilaterally <input type="checkbox"/>
Abdomen	Soft, no masses, liver & spleen normal <input type="checkbox"/>
Genitalia	Grossly normal <input type="checkbox"/>

Comprehensive Health Assessment

Male	Circ / uncircumcised, testes in scrotum	<input type="checkbox"/>
Female	No lesions, normal external appearance	<input type="checkbox"/>
Hips	Good abduction	<input type="checkbox"/>
Femoral pulses	Normal	<input type="checkbox"/>
Extremities	No deformities, full ROM	<input type="checkbox"/>
Skin	Clear, no significant lesions	<input type="checkbox"/>
Neurologic	Alert, no gross sensory or motor deficit	<input type="checkbox"/>
Subjective / Objective		
Assessment		
Plan		
Referrals		
<input type="checkbox"/> WIC	<input type="checkbox"/> Optometrist / Ophthalmologist	<input type="checkbox"/> Audiologist
<input type="checkbox"/> Dentist	<input type="checkbox"/> Dietician / Nutritionist	<input type="checkbox"/> Pulmonologist
<input type="checkbox"/> CA Children's Services (CCS)	<input type="checkbox"/> Regional Center	<input type="checkbox"/> Early Start or Local Education Agency
<input type="checkbox"/> Other:		
Orders		
<input type="checkbox"/> COVID 19 vaccine	<input type="checkbox"/> MMR	<input type="checkbox"/> CBC / Basic metabolic panel
<input type="checkbox"/> DTaP	<input type="checkbox"/> PPSV	<input type="checkbox"/> Hct / Hgb (if high risk)
<input type="checkbox"/> Hep A vaccine (if not up to date)	<input type="checkbox"/> PPSV (if high risk)	<input type="checkbox"/> Lipid panel (if high risk)
<input type="checkbox"/> Hep B vaccine (if not up to date)	<input type="checkbox"/> Varicella (2 nd Dose)	<input type="checkbox"/> PPD skin test
<input type="checkbox"/> IPV	<input type="checkbox"/> Blood Lead (if not in chart)	<input type="checkbox"/> QFT
<input type="checkbox"/> Influenza vaccine	<input type="checkbox"/> Hep B Panel (if high risk)	<input type="checkbox"/> CXR
<input type="checkbox"/> Meningococcal (if high risk)	<input type="checkbox"/> Rx Fluoride drops / chewable tabs (0.25 mg/0.50 mg QD)	<input type="checkbox"/> Urinalysis
<input type="checkbox"/> ECG	<input type="checkbox"/> Fluoride varnish application	<input type="checkbox"/> COVID 19 test
<input type="checkbox"/> Other:		

Name: _____ DOB: _____ MR#: _____

Anticipatory Guidance (AG) / Education (✓ if discussed)		
Health education preference: <input type="checkbox"/> Verbal <input type="checkbox"/> Visual <input type="checkbox"/> Multimedia <input type="checkbox"/> Other:		
Diet, Nutrition & Exercise		
<input type="checkbox"/> Weight control / obesity	<input type="checkbox"/> Vegetables, fruits	<input type="checkbox"/> Meal socialization
<input type="checkbox"/> Whole grains / iron-rich foods	<input type="checkbox"/> Limit fatty, sugary & salty foods	<input type="checkbox"/> Limit candy, chips & ice cream
<input type="checkbox"/> Physical activity / exercise	<input type="checkbox"/> Regular balanced meal with snacks	<input type="checkbox"/> School lunch program
Accident Prevention & Guidance		
<input type="checkbox"/> Lead poisoning prevention	<input type="checkbox"/> Seat belt / Toddler car seat	<input type="checkbox"/> Independence
<input type="checkbox"/> Routine dental care	<input type="checkbox"/> Safety helmet	<input type="checkbox"/> Make-believe / role play
<input type="checkbox"/> Brush teeth with fluoride toothpaste	<input type="checkbox"/> Storage of drugs / toxic chemicals	<input type="checkbox"/> Dressing self
<input type="checkbox"/> Fluoride varnish treatment	<input type="checkbox"/> Matches / burns	<input type="checkbox"/> Reading together / school readiness
<input type="checkbox"/> Family support, social interaction & communication	<input type="checkbox"/> Violence prevention, gun safety	<input type="checkbox"/> Knows name, address, & phone number
<input type="checkbox"/> Caution with strangers	<input type="checkbox"/> Poison control phone number	<input type="checkbox"/> Plays with other children
<input type="checkbox"/> Skin cancer prevention	<input type="checkbox"/> Smoke detector	<input type="checkbox"/> Limit screen time
<input type="checkbox"/> Falls	<input type="checkbox"/> Hot water temp < 120° F	<input type="checkbox"/> Bedtime
<input type="checkbox"/> Effects of passive smoking	<input type="checkbox"/> Drowning / pool fence	<input type="checkbox"/> Toileting habits
Next Appointment		
<input type="checkbox"/> At 4 Years Old	<input type="checkbox"/> RTC PRN	<input type="checkbox"/> Other:

Documentation Reminders		
<input type="checkbox"/> Screening tools (TB, HEP B, etc.) are completed, dated, & reviewed by provider	<input type="checkbox"/> Height / Weight / BMI measurements plotted in CDC growth chart	<input type="checkbox"/> Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date
Provider Signature	Title	Date

Notes (include date, time, signature, and title on all entries)
<input type="checkbox"/> Member/parent refused the following screening/orders:

Comprehensive Health Assessment

4 to 5 Years Old	Actual Age: _____ Date: _____
Sex at Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female
Accompanied by	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other: _____
Parent's Primary Language	_____
Interpreter Requested	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused Name of Interpreter: _____
Intake	(See CDC Growth Chart) Vital Signs
Height	Temp _____
Weight	BP _____
BMI Value	Pulse _____
BMI %	Resp _____
Allergies / Reaction	_____
Pain	Location: _____ Scale: 0 1 2 3 4 5 6 7 8 9 10
Hearing Screening	<input type="checkbox"/> Responded at ≤ 25 dB at 1000-4000 frequencies in both ears <input type="checkbox"/> Non coop
Vision Screening	OD: _____ OS: _____ OU: _____ <input type="checkbox"/> Non coop
Cultural Needs (e.g., cultural background/traditions, religious practices, dietary preference/restrictions, and healthcare beliefs):	<input type="checkbox"/> Unremarkable
Birth Weight: _____ Birth Length: _____ Gestational Age: _____ Delivery: <input type="checkbox"/> Vaginal <input type="checkbox"/> C-section Complications: <input type="checkbox"/> Yes <input type="checkbox"/> No Country of Birth: <input type="checkbox"/> US <input type="checkbox"/> Other: _____ At least 1 parent born in Africa, Asia, Pacific Islands: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Chronic Problems/Significant Conditions: <input type="checkbox"/> None <input type="checkbox"/> See Problem List <input type="checkbox"/> Asthma <input type="checkbox"/> Cancer <input type="checkbox"/> DM <input type="checkbox"/> Dialysis <input type="checkbox"/> Heart Disease <input type="checkbox"/> HEP B <input type="checkbox"/> HEP C <input type="checkbox"/> HIV <input type="checkbox"/> HTN <input type="checkbox"/> Liver Disease <input type="checkbox"/> Seizures <input type="checkbox"/> Uses DME <input type="checkbox"/> ≥ 2 ER visits in 12 months <input type="checkbox"/> Other: _____	
Current Medications/Vitamins: <input type="checkbox"/> See Medication List	
Interval History	
Dental Home	Dental visit within past 12 months: <input type="checkbox"/> Yes <input type="checkbox"/> No Drinks fluoridated water or takes supplements: <input type="checkbox"/> Yes <input type="checkbox"/> No Fluoride varnish applied in last 6 months: <input type="checkbox"/> Yes <input type="checkbox"/> No
Diet / Nutrition	<input type="checkbox"/> Regular <input type="checkbox"/> Iron-rich foods <input type="checkbox"/> Other: _____
Appetite	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
Elimination	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Has WIC	<input type="checkbox"/> Yes <input type="checkbox"/> No
Physical Activity	<input type="checkbox"/> Inactive (little or none) <input type="checkbox"/> Some (< 2 ½ hrs/week) <input type="checkbox"/> Active (> 60 min/day) <input type="checkbox"/> Fainting <input type="checkbox"/> Sudden seizures <input type="checkbox"/> SOB <input type="checkbox"/> Chest pain
Sleep Pattern	<input type="checkbox"/> Regular <input type="checkbox"/> Fatigue <input type="checkbox"/> Snoring <input type="checkbox"/> Enuresis
Vaccines Up to Date	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> See CAIR

Name:	DOB:	MR#:	
Family History	<input type="checkbox"/> Unremarkable <input type="checkbox"/> Diabetes		
<input type="checkbox"/> Heart disease / HTN	<input type="checkbox"/> Lives/lived with someone HBV+	<input type="checkbox"/> Asthma	
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Cancer	<input type="checkbox"/> Family Hx of unexpected or sudden death < 50 yrs	
<input type="checkbox"/> Anemia	<input type="checkbox"/> Other: _____		
Dyadic Behavioral / Social Determinants of Health (SDOH)	<input type="checkbox"/> WNL - Stable relationships w/ social/emotional support <input type="checkbox"/> Changes in family since last visit (move, job, death) <input type="checkbox"/> Problems with housing, food, employment <input type="checkbox"/> Family stressors (mental illness, drugs, violence/abuse)		
Lives with	<input type="checkbox"/> 1 Parent <input type="checkbox"/> 2 Parents <input type="checkbox"/> Other: _____		
AAP Risk Screener	Screening Tools Used	Low Risk	
		High Risk (see Plan/Orders/AG)	
Adverse Childhood Experiences	<input type="checkbox"/> PEARLS , <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Blood Lead Education (At each Well Visit)	<input type="checkbox"/> Lead Assessment , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Dental (cavities, no dental home)	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Dyadic Behavioral / SDOH	<input type="checkbox"/> SDOH , <input type="checkbox"/> PEARLS , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Dyslipidemia	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B	<input type="checkbox"/> CDC HEP Risk , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco Use / Exposure	<input type="checkbox"/> SHA , <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis Exposure	<input type="checkbox"/> TB Risk Assessment , <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Growth and Development / School Progress Grade: _____			
<input type="checkbox"/> Hops on one foot	<input type="checkbox"/> Counts four pennies	<input type="checkbox"/> Copies a square	
<input type="checkbox"/> Catches, throws a ball	<input type="checkbox"/> Knows opposites	<input type="checkbox"/> Recognizes 3-4 colors	
<input type="checkbox"/> Plays with several children	<input type="checkbox"/> Knows name, address, & phone number	<input type="checkbox"/> Holds crayon between finger and thumb	
Physical Examination			WNL
General appearance	Well-nourished & developed No abuse/neglect evident	<input type="checkbox"/>	
Head	Symmetrical	<input type="checkbox"/>	
Eyes	PERRLA, conjunctivae & sclerae clear Red reflexes present, No strabismus Appears to see	<input type="checkbox"/>	
Ears	Canals clear, TMs normal Appears to hear	<input type="checkbox"/>	
Nose	Passages clear, MM pink, no lesions	<input type="checkbox"/>	
Teeth	No visible cavities, grossly normal	<input type="checkbox"/>	
Mouth / Pharynx	Oral mucosa pink, no lesions	<input type="checkbox"/>	
Neck	Supple, no masses, thyroid not enlarged	<input type="checkbox"/>	
Chest / Breast	Symmetrical, no masses	<input type="checkbox"/>	
Heart	No organic murmurs, regular rhythm	<input type="checkbox"/>	
Lungs	Clear to auscultation bilaterally	<input type="checkbox"/>	
Abdomen	Soft, no masses, liver & spleen normal	<input type="checkbox"/>	

Comprehensive Health Assessment

Genitalia	Grossly normal	<input type="checkbox"/>
Male	Circ / uncircumcised, testes in scrotum	<input type="checkbox"/>
Female	No lesions, normal external appearance	<input type="checkbox"/>
Hips	Good abduction	<input type="checkbox"/>
Femoral pulses	Normal	<input type="checkbox"/>
Extremities	No deformities, full ROM	<input type="checkbox"/>
Skin	Clear, no significant lesions	<input type="checkbox"/>
Neurologic	Alert, no gross sensory or motor deficit	<input type="checkbox"/>
Subjective / Objective		
Assessment		
Plan		
Referrals		
<input type="checkbox"/> WIC	<input type="checkbox"/> Optometrist / Ophthalmologist	<input type="checkbox"/> Audiologist
<input type="checkbox"/> Dentist	<input type="checkbox"/> Dietician / Nutritionist	<input type="checkbox"/> Pulmonologist
<input type="checkbox"/> CA Children's Services (CCS)	<input type="checkbox"/> Regional Center	<input type="checkbox"/> Early Start or Local Education Agency
<input type="checkbox"/> Other:		
Orders		
<input type="checkbox"/> COVID 19 vaccine	<input type="checkbox"/> MMR	<input type="checkbox"/> CBC / Basic metabolic panel
<input type="checkbox"/> DTaP	<input type="checkbox"/> PCV13 (if not up to date)	<input type="checkbox"/> Hct / Hgb (if high risk)
<input type="checkbox"/> Hep A vaccine (if not up to date)	<input type="checkbox"/> PPSV (if high risk)	<input type="checkbox"/> Lipid panel (if high risk)
<input type="checkbox"/> Hep B vaccine (if not up to date)	<input type="checkbox"/> Varicella (2 nd Dose)	<input type="checkbox"/> PPD skin test <input type="checkbox"/> QFT
<input type="checkbox"/> IPV	<input type="checkbox"/> Blood Lead (if not in chart)	<input type="checkbox"/> CXR <input type="checkbox"/> Urinalysis at 5 years
<input type="checkbox"/> Influenza vaccine	<input type="checkbox"/> Hep B Panel (if high risk)	<input type="checkbox"/> ECG <input type="checkbox"/> COVID 19 test
<input type="checkbox"/> Meningococcal (if high risk)	<input type="checkbox"/> Rx Fluoride drops / chewable tabs (0.25 mg/0.50 mg QD)	<input type="checkbox"/> Fluoride varnish application
<input type="checkbox"/> Other:		

Name: _____ DOB: _____ MR#: _____

Anticipatory Guidance (AG) / Education (✓ if discussed)		
Health education preference: <input type="checkbox"/> Verbal <input type="checkbox"/> Visual <input type="checkbox"/> Multimedia <input type="checkbox"/> Other:		
Diet, Nutrition & Exercise		
<input type="checkbox"/> Weight control / obesity	<input type="checkbox"/> Vegetables, fruits	<input type="checkbox"/> Meal socialization
<input type="checkbox"/> Whole grains / iron-rich foods	<input type="checkbox"/> Limit fatty, sugary & salty foods	<input type="checkbox"/> Limit candy, chips & ice cream
<input type="checkbox"/> Physical activity / exercise	<input type="checkbox"/> Regular balanced meal with snacks	<input type="checkbox"/> School lunch program
Accident Prevention & Guidance		
<input type="checkbox"/> Lead poisoning prevention	<input type="checkbox"/> Seat belt	<input type="checkbox"/> Independence
<input type="checkbox"/> Routine dental care	<input type="checkbox"/> Safety helmet	<input type="checkbox"/> Make-believe / role play
<input type="checkbox"/> Brush teeth with fluoride toothpaste	<input type="checkbox"/> Storage of drugs / toxic chemicals	<input type="checkbox"/> Dressing self
<input type="checkbox"/> Fluoride varnish treatment	<input type="checkbox"/> Matches / burns	<input type="checkbox"/> Reading together / school readiness
<input type="checkbox"/> Family support, social interaction & communication	<input type="checkbox"/> Violence prevention, gun safety	<input type="checkbox"/> Knows name, address, & phone number
<input type="checkbox"/> Caution with strangers	<input type="checkbox"/> Poison control phone number	<input type="checkbox"/> Plays with other children
<input type="checkbox"/> Skin cancer prevention	<input type="checkbox"/> Smoke detector	<input type="checkbox"/> Limit screen time
<input type="checkbox"/> Falls	<input type="checkbox"/> Hot water temp < 120° F	<input type="checkbox"/> Bedtime
<input type="checkbox"/> Effects of passive smoking	<input type="checkbox"/> Drowning / pool fence	<input type="checkbox"/> Toileting habits
Next Appointment		
<input type="checkbox"/> 1 year	<input type="checkbox"/> RTC PRN	<input type="checkbox"/> Other:

Documentation Reminders		
<input type="checkbox"/> Screening tools (TB, HEP B, etc.) are completed, dated, & reviewed by provider	<input type="checkbox"/> Height / Weight / BMI measurements plotted in CDC growth chart	<input type="checkbox"/> Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date
Provider Signature	Title	Date

Notes (include date, time, signature, and title on all entries)		
<input type="checkbox"/> Member/parent refused the following screening/orders:		

Comprehensive Health Assessment

6 to 8 Years Old	Actual Age: _____ Date: _____
Sex at Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female
Accompanied By	<input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Other:
Parent's Primary Language	
Interpreter Requested	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused Name of Interpreter: _____
Intake	(See CDC Growth Chart) Vital Signs
Height	Temp
Weight	BP
BMI Value	Pulse
BMI %	Resp
Allergies / Reaction	
Pain	Location: _____ Scale: 0 1 2 3 4 5 6 7 8 9 10
Hearing Screening	<input type="checkbox"/> Responded at ≤ 25 dB at 1000-4000 frequencies in both ears <input type="checkbox"/> Non coop
Vision Screening	OD: _____ OS: _____ OU: _____ <input type="checkbox"/> Non coop
Cultural Needs (e.g., cultural background/traditions, religious practices, dietary preference/restrictions, and healthcare beliefs):	<input type="checkbox"/> Unremarkable
Country of Birth: <input type="checkbox"/> US <input type="checkbox"/> Other: _____ At least 1 parent born in Africa, Asia, Pacific Islands: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Chronic Problems/Significant Conditions: <input type="checkbox"/> None <input type="checkbox"/> See Problem List <input type="checkbox"/> Asthma <input type="checkbox"/> Cancer <input type="checkbox"/> Depression <input type="checkbox"/> DM <input type="checkbox"/> Dialysis <input type="checkbox"/> Heart Disease <input type="checkbox"/> HEP B <input type="checkbox"/> HEP C <input type="checkbox"/> HIV <input type="checkbox"/> HTN <input type="checkbox"/> Liver Disease <input type="checkbox"/> Seizures <input type="checkbox"/> Uses DME <input type="checkbox"/> ≥ 2 ER visits in 12 months <input type="checkbox"/> Other: _____	
Current Medications/Vitamins: <input type="checkbox"/> See Medication List	
Interval History	
Dental Home	Dental visit within past 12 months: <input type="checkbox"/> Yes <input type="checkbox"/> No Drinks fluoridated water or takes supplements: <input type="checkbox"/> Yes <input type="checkbox"/> No
Diet / Nutrition	<input type="checkbox"/> Regular <input type="checkbox"/> Iron-rich foods <input type="checkbox"/> Other:
Appetite	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
Physical Activity	<input type="checkbox"/> Inactive (little or none) <input type="checkbox"/> Some (< 2 ½ hrs/week) <input type="checkbox"/> Active (≥ 60 min/day) <input type="checkbox"/> Fainting <input type="checkbox"/> Sudden seizures <input type="checkbox"/> SOB <input type="checkbox"/> Chest pain
Sleep Pattern	<input type="checkbox"/> Regular <input type="checkbox"/> Fatigue <input type="checkbox"/> Snoring <input type="checkbox"/> Enuresis
Vaccines Up to Date	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> See CAIR
Family History	<input type="checkbox"/> Unremarkable <input type="checkbox"/> Diabetes
<input type="checkbox"/> Heart disease / HTN	<input type="checkbox"/> Lives/lived with someone HBV+ <input type="checkbox"/> Asthma
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Cancer <input type="checkbox"/> Family Hx of unexpected or sudden death < 50 yrs
<input type="checkbox"/> Anemia	<input type="checkbox"/> Other: _____
Dyadic Behavioral / Social Determinants of Health (SDOH)	<input type="checkbox"/> WNL - Stable relationships w/ social/emotional support <input type="checkbox"/> Changes in family since last visit (move, job, death) <input type="checkbox"/> Problems with housing, food, employment <input type="checkbox"/> Family stressors (mental illness, drugs, violence/abuse)
Lives with	<input type="checkbox"/> 1 Parent <input type="checkbox"/> 2 Parents <input type="checkbox"/> Other: _____

Name: _____		DOB: _____	MR#: _____
AAP Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/Orders/AG)
Adverse Childhood Experiences	<input type="checkbox"/> PEARLS , <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Dental (cavities, no dental home)	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Dyadic Behavioral / SDOH	<input type="checkbox"/> SDOH , <input type="checkbox"/> PEARLS , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Dyslipidemia	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B	<input type="checkbox"/> CDC HEP Risk , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Sudden Cardiac Arrest	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco Use / Exposure	<input type="checkbox"/> SHA , <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis Exposure	<input type="checkbox"/> TB Risk Assessment , <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Growth and Development / School Progress Grade: _____			
<input type="checkbox"/> Rides bicycle	<input type="checkbox"/> Knows right from left	<input type="checkbox"/> Reads for pleasure	
<input type="checkbox"/> Ties shoelaces	<input type="checkbox"/> Draws person with 6 parts including clothing	<input type="checkbox"/> Tells time	
<input type="checkbox"/> Rules and consequences	<input type="checkbox"/> Independence	<input type="checkbox"/> Prints first name	
Physical Examination			WNL
General appearance	Well-nourished & developed No abuse/neglect evident	<input type="checkbox"/>	
Head	No lesions	<input type="checkbox"/>	
Eyes	PERRLA, conjunctivae & sclerae clear Vision grossly normal	<input type="checkbox"/>	
Ears	Canals clear, TMs normal Hearing grossly normal	<input type="checkbox"/>	
Nose	Passages clear, MM pink, no lesions	<input type="checkbox"/>	
Teeth	No visible cavities & grossly normal	<input type="checkbox"/>	
Mouth / Pharynx	Oral mucosa pink, no lesions	<input type="checkbox"/>	
Chest / Breast	Symmetrical, no masses	<input type="checkbox"/>	
Heart	No organic murmurs, regular rhythm	<input type="checkbox"/>	
Lungs	Clear to auscultation bilaterally	<input type="checkbox"/>	
Abdomen	Soft, no masses, liver & spleen normal	<input type="checkbox"/>	
Genitalia	Grossly normal	<input type="checkbox"/>	
Male	Circ / uncircumcised, testes in scrotum	<input type="checkbox"/>	
Female	No lesions, normal external appearance	<input type="checkbox"/>	
Femoral pulses	Normal	<input type="checkbox"/>	
Extremities	No deformities, full ROM	<input type="checkbox"/>	
Lymph nodes	Not enlarged	<input type="checkbox"/>	
Back	No scoliosis	<input type="checkbox"/>	
Skin	Clear, no significant lesions	<input type="checkbox"/>	
Neurologic	Alert, no gross sensory or motor deficit	<input type="checkbox"/>	

Comprehensive Health Assessment

9 to 12 Years Old	Actual Age: _____ Date: _____
Sex at Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female
Accompanied By	<input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Other: _____
Primary Language	_____
Interpreter Requested	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused Name of Interpreter: _____
Intake	(See CDC Growth Chart) Vital Signs
Height	Temp _____
Weight	BP _____
BMI Value	Pulse _____
BMI %	Resp _____
Allergies / Reaction	_____
Pain	Location: _____ Scale: 0 1 2 3 4 5 6 7 8 9 10
Hearing Screening	<input type="checkbox"/> 9-10 Yrs Old: Responded at \leq 25 dB at 1000-4000 frequencies in both ears <input type="checkbox"/> Non coop <input type="checkbox"/> \geq 11 Yrs Old: Responded at \leq 25 dB at 1000-8000 frequencies in both ears
Vision Screening	OD: _____ OS: _____ OU: _____ <input type="checkbox"/> Non coop
Cultural Needs (e.g., cultural background/traditions, religious practices, dietary preference/restrictions, and healthcare beliefs): <input type="checkbox"/> Unremarkable	
Country of Birth: <input type="checkbox"/> US <input type="checkbox"/> Other: _____ At least 1 parent born in Africa, Asia, Pacific Islands: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Chronic Problems/Significant Conditions: <input type="checkbox"/> None <input type="checkbox"/> See Problem List <input type="checkbox"/> Asthma <input type="checkbox"/> Cancer <input type="checkbox"/> Depression <input type="checkbox"/> DM <input type="checkbox"/> Dialysis <input type="checkbox"/> Heart Disease <input type="checkbox"/> HEP B <input type="checkbox"/> HEP C <input type="checkbox"/> High Cholesterol <input type="checkbox"/> HIV <input type="checkbox"/> HTN <input type="checkbox"/> Liver Disease <input type="checkbox"/> Seizures <input type="checkbox"/> STI <input type="checkbox"/> Uses DME <input type="checkbox"/> \geq 2 ER visits in 12 months <input type="checkbox"/> Other: _____	
Current Medications/Vitamins: <input type="checkbox"/> See Medication List	
Interval History	
Dental Home	Dental visit within past 12 months: <input type="checkbox"/> Yes <input type="checkbox"/> No Drinks fluoridated water or takes supplements: <input type="checkbox"/> Yes <input type="checkbox"/> No
Diet / Nutrition	<input type="checkbox"/> Regular <input type="checkbox"/> Low calorie <input type="checkbox"/> ADA <input type="checkbox"/> Iron-rich foods <input type="checkbox"/> Other: _____
Appetite	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
Physical Activity	<input type="checkbox"/> Inactive (little or none) <input type="checkbox"/> Some (< 2 1/2 hrs/week) <input type="checkbox"/> Active (\geq 60 min/day) <input type="checkbox"/> Fainting <input type="checkbox"/> Sudden seizures <input type="checkbox"/> SOB <input type="checkbox"/> Chest pain
Sleep Pattern	<input type="checkbox"/> Regular <input type="checkbox"/> Fatigue <input type="checkbox"/> Snoring <input type="checkbox"/> Enuresis
Vaccines Up to Date	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> See CAIR
Sexually active	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Multiple Partners <input type="checkbox"/> MSM
Contraceptive Used	<input type="checkbox"/> None <input type="checkbox"/> Condoms <input type="checkbox"/> Other: _____
LMP (females):	<input type="checkbox"/> Menorrhagia
Current Alcohol / Substance Use	<input type="checkbox"/> None <input type="checkbox"/> Alcohol
<input type="checkbox"/> Drugs (specify):	<input type="checkbox"/> IV Drugs-Current <input type="checkbox"/> Other: _____ <input type="checkbox"/> IV Drugs-Past Hx

Name: _____ DOB: _____ MR#: _____

Family History	<input type="checkbox"/> Unremarkable <input type="checkbox"/> Diabetes
<input type="checkbox"/> Heart disease / HTN	<input type="checkbox"/> Lives/lived with someone HBV+ <input type="checkbox"/> Asthma
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Cancer <input type="checkbox"/> Family Hx of unexpected or sudden death < 50 yrs
<input type="checkbox"/> Anemia	<input type="checkbox"/> Other: _____
Dyadic Behavioral / Social Determinants of Health (SDOH)	<input type="checkbox"/> WNL - Stable relationships w/ social/emotional support <input type="checkbox"/> Changes in family since last visit (move, job, death) <input type="checkbox"/> Problems with housing, food, employment <input type="checkbox"/> Family stressors (mental illness, drugs, violence/abuse)
Lives with	<input type="checkbox"/> 1 Parent <input type="checkbox"/> 2 Parents <input type="checkbox"/> Other: _____
AAP Risk Screener	Screening Tools Used Low Risk High Risk (see Plan/Orders/AG)
Adverse Childhood Experiences	<input type="checkbox"/> PEARLS, <input type="checkbox"/> PEARLS-12&UP <input type="checkbox"/> Other: _____
Alcohol Misuse (Starting at 11 yrs old)	<input type="checkbox"/> SHA, <input type="checkbox"/> CRAFFT, <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____
Anemia	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____
Dental (cavities, no dental home)	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____
Depression Score: (Starting at 12 yrs old)	<input type="checkbox"/> PHQ-9A, <input type="checkbox"/> Other: _____
Drug Misuse (Starting at 11 years old)	<input type="checkbox"/> SHA, <input type="checkbox"/> CRAFFT, <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____
Dyadic Behavioral / SDOH	<input type="checkbox"/> SDOH, <input type="checkbox"/> PEARLS, <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____
Dyslipidemia	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____
Hepatitis B	<input type="checkbox"/> CDC HEP Risk, <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____
HIV (Starting at 11 yrs old)	<input type="checkbox"/> SHA, <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____
Sexually Transmitted Infections (Starting at 11 yrs old)	<input type="checkbox"/> SHA, <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____
Sudden Cardiac Arrest (Starting at 11 yrs old)	<input type="checkbox"/> SCD, <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____
Suicide (Starting at 12 yrs old)	<input type="checkbox"/> ASQ, <input type="checkbox"/> PHQ-9A, <input type="checkbox"/> Other: _____
Tobacco Use / Exposure	<input type="checkbox"/> SHA, <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____
Tuberculosis Exposure	<input type="checkbox"/> TB Risk Assessment, <input type="checkbox"/> Other: _____
Growth and Development / School Progress Grade: _____	
<input type="checkbox"/> School achievement	<input type="checkbox"/> Performs chores <input type="checkbox"/> Plays / listens to music
<input type="checkbox"/> School attendance	<input type="checkbox"/> Exhibit compassion & empathy <input type="checkbox"/> Reads for pleasure
<input type="checkbox"/> Cause and effect are understood	<input type="checkbox"/> Participates in organized sports / social activities <input type="checkbox"/> Demonstrate social & emotional competence (including self-regulation)
<input type="checkbox"/> Caring & supportive relationships with family & peers	<input type="checkbox"/> Adheres to predetermined rules <input type="checkbox"/> Knows right from left
Physical Examination WNL	
General appearance	Well-nourished & developed No abuse/neglect evident <input type="checkbox"/>

Comprehensive Health Assessment

Head	No lesions	<input type="checkbox"/>
Eyes	PERRLA, conjunctivae & sclerae clear Vision grossly normal	<input type="checkbox"/>
Ears	Canals clear, TMs normal Hearing grossly normal	<input type="checkbox"/>
Nose	Passages clear, MM pink, no lesions	<input type="checkbox"/>
Teeth	No visible cavities, grossly normal	<input type="checkbox"/>
Mouth / Pharynx	Oral mucosa pink, no lesions	<input type="checkbox"/>
Neck	Supple, no masses, thyroid not enlarged	<input type="checkbox"/>
Chest / Breast (females)	Symmetrical, no masses Tanner stage: I II III IV V	<input type="checkbox"/>
Heart	No organic murmurs, regular rhythm	<input type="checkbox"/>
Lungs	Clear to auscultation bilaterally	<input type="checkbox"/>
Abdomen	Soft, no masses, liver & spleen normal	<input type="checkbox"/>
Genitalia	Grossly normal Tanner stage: I II III IV V	<input type="checkbox"/>
Male	Circ / uncircumcised, testes in scrotum	<input type="checkbox"/>
Female	No lesions, normal external appearance	<input type="checkbox"/>
Femoral pulses	Normal	<input type="checkbox"/>
Extremities	No deformities, full ROM	<input type="checkbox"/>
Lymph nodes	Not enlarged	<input type="checkbox"/>
Back	No scoliosis	<input type="checkbox"/>
Skin	Clear, no significant lesions	<input type="checkbox"/>
Neurologic	Alert, no gross sensory or motor deficit	<input type="checkbox"/>
Subjective / Objective		
Assessment		
Plan		
Referrals		
<input type="checkbox"/> Dentist	<input type="checkbox"/> Optometrist / Ophthalmologist	<input type="checkbox"/> Dietician / Nutritionist
<input type="checkbox"/> Drug / ETOH Tx rehab	<input type="checkbox"/> Behavioral health	<input type="checkbox"/> Tobacco cessation class
<input type="checkbox"/> CA Children's Services (CCS)	<input type="checkbox"/> Regional Center	<input type="checkbox"/> Early Start or Local Education Agency
<input type="checkbox"/> OB/GYN:	<input type="checkbox"/> Other:	
Orders		
<input type="checkbox"/> COVID 19 vaccine	<input type="checkbox"/> Tdap	<input type="checkbox"/> CBC / Basic metabolic panel
<input type="checkbox"/> Hep B vaccine (if not given previously)	<input type="checkbox"/> Varicella (if not up to date)	<input type="checkbox"/> Hct / Hgb (yearly if menstruating)
<input type="checkbox"/> HPV vaccine (if not up to date)	<input type="checkbox"/> Hep B Panel (if not up to date)	<input type="checkbox"/> Lipid panel (once between 9-11 yrs)
<input type="checkbox"/> Influenza vaccine	<input type="checkbox"/> Chlamydia	<input type="checkbox"/> PPD skin test
	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> QFT
<input type="checkbox"/> Meningococcal vaccine (11 to 12 yrs)	<input type="checkbox"/> HIV (if high risk)	<input type="checkbox"/> CXR
	<input type="checkbox"/> Herpes	<input type="checkbox"/> Urinalysis
<input type="checkbox"/> MMR (if not up to date)	<input type="checkbox"/> Syphilis	<input type="checkbox"/> ECG

Name: _____ DOB: _____ MR#: _____

<input type="checkbox"/> Trichomonas	<input type="checkbox"/> COVID 19 test	
<input type="checkbox"/> Rx Fluoride drops / chewable tabs (0.50 mg/1.0 mg QD)	<input type="checkbox"/> Other:	
Anticipatory Guidance (AG) / Education (✓ if discussed)		
Health education preference: <input type="checkbox"/> Verbal <input type="checkbox"/> Visual <input type="checkbox"/> Multimedia <input type="checkbox"/> Other:		
Diet, Nutrition & Exercise		
<input type="checkbox"/> Weight control / obesity	<input type="checkbox"/> Vegetables, fruits	<input type="checkbox"/> Lean protein
<input type="checkbox"/> Whole grains / iron-rich foods	<input type="checkbox"/> Limit fatty, sugary & salty foods	<input type="checkbox"/> Limit candy, chips & ice cream
<input type="checkbox"/> Physical activity / exercise	<input type="checkbox"/> Healthy food choices	<input type="checkbox"/> Eating disorder
Accident Prevention & Guidance		
<input type="checkbox"/> Alcohol/drug/substance misuse counseling	<input type="checkbox"/> Social media use	<input type="checkbox"/> Peer pressure
<input type="checkbox"/> Signs of depression (suicidal ideation)	<input type="checkbox"/> Avoid risk-taking behavior	<input type="checkbox"/> Independence
<input type="checkbox"/> Mental health (emotional support)	<input type="checkbox"/> Gun safety	<input type="checkbox"/> Personal development
<input type="checkbox"/> Form caring & supportive relationships with family & peers	<input type="checkbox"/> Non-violent conflict resolution	<input type="checkbox"/> Physical growth
<input type="checkbox"/> Early Sex education / Safe sex practices	<input type="checkbox"/> Safety helmet	<input type="checkbox"/> Mindful of daily movements
<input type="checkbox"/> Skin cancer prevention	<input type="checkbox"/> Seat belt	<input type="checkbox"/> Puberty
<input type="checkbox"/> Smoking/vaping use/exposure	<input type="checkbox"/> Routine dental care	<input type="checkbox"/> Bedtime
Tobacco Use / Cessation Exposed to 2 nd hand smoke <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Never smoked or used tobacco products		
<input type="checkbox"/> Former smoker: # Yrs smoked ____ # Cigarettes smoked/day ____ Quit date ____		
<input type="checkbox"/> Current smoker: # Yrs smoked ____ # Cigarettes smoked/day ____		
Type used: <input type="checkbox"/> Cigarettes <input type="checkbox"/> Chewing tobacco <input type="checkbox"/> Vaping products <input type="checkbox"/> Other:		
<input type="checkbox"/> Advised to quit smoking	<input type="checkbox"/> Discussed smoking cessation medication	<input type="checkbox"/> Discussed smoking cessation strategies
Next Appointment		
<input type="checkbox"/> 1 year	<input type="checkbox"/> RTC PRN	<input type="checkbox"/> Other:

Documentation Reminders		
<input type="checkbox"/> Screening tools (TB, Depression/Suicide, HEP B, etc.) are completed, dated, & reviewed by provider	<input type="checkbox"/> Height / Weight / BMI measurements plotted in CDC growth chart	<input type="checkbox"/> Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date
Provider Signature	Title	Date

Notes (include date, time, signature, and title on all entries)
<input type="checkbox"/> Member/parent refused the following screening/orders:

Comprehensive Health Assessment

13 to 16 Years Old	Actual Age: _____ Date: _____
Sex at Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female
Accompanied By	<input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Other:
Primary Language	
Interpreter Requested	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused Name of Interpreter: _____
Intake	(See CDC Growth Chart) Vital Signs
Height	Temp
Weight	BP
BMI Value	Pulse
BMI %	Resp
Allergies / Reaction	
Pain	Location: _____ Scale: 0 1 2 3 4 5 6 7 8 9 10
Hearing Screening	<input type="checkbox"/> Responded at ≤ 25 dB at 1000-8000 frequencies in both ears <input type="checkbox"/> Non coop
Vision Screening	OD: _____ OS: _____ OU: _____ <input type="checkbox"/> Non coop
Cultural Needs (e.g., cultural background/traditions, religious practices, dietary preference/restrictions, and healthcare beliefs): <input type="checkbox"/> Unremarkable	
Country of Birth: <input type="checkbox"/> US <input type="checkbox"/> Other: _____ At least 1 parent born in Africa, Asia, Pacific Islands: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Chronic Problems/Significant Conditions: <input type="checkbox"/> None <input type="checkbox"/> See Problem List <input type="checkbox"/> Asthma <input type="checkbox"/> Cancer <input type="checkbox"/> Depression <input type="checkbox"/> DM <input type="checkbox"/> Dialysis <input type="checkbox"/> Heart Disease <input type="checkbox"/> HEP B <input type="checkbox"/> HEP C <input type="checkbox"/> High Cholesterol <input type="checkbox"/> HIV <input type="checkbox"/> HTN <input type="checkbox"/> Liver Disease <input type="checkbox"/> Seizures <input type="checkbox"/> STI <input type="checkbox"/> Uses DME <input type="checkbox"/> ≥ 2 ER visits in 12 months <input type="checkbox"/> Other:	
Current Medications/Vitamins: <input type="checkbox"/> See Medication List	
Interval History	
Dental Home	Dental visit within past 12 months: <input type="checkbox"/> Yes <input type="checkbox"/> No Drinks fluoridated water or takes supplements: <input type="checkbox"/> Yes <input type="checkbox"/> No
Diet / Nutrition	<input type="checkbox"/> Regular <input type="checkbox"/> Low calorie <input type="checkbox"/> ADA <input type="checkbox"/> Iron-rich foods <input type="checkbox"/> Other:
Appetite	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
Physical Activity	<input type="checkbox"/> Inactive (little or none) <input type="checkbox"/> Some (< 2 ½ hrs/week) <input type="checkbox"/> Active (≥ 60 min/day) <input type="checkbox"/> Fainting <input type="checkbox"/> Sudden seizures <input type="checkbox"/> SOB <input type="checkbox"/> Chest pain
Vaccines Up to Date	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> See CAIR
Sexually Active	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Multiple Partners <input type="checkbox"/> MSM
Contraceptive Used	<input type="checkbox"/> None <input type="checkbox"/> Condoms <input type="checkbox"/> Other:
LMP (females):	<input type="checkbox"/> Menorrhagia
Current Alcohol / Substance Use	<input type="checkbox"/> None <input type="checkbox"/> Alcohol
<input type="checkbox"/> Drugs (specify):	<input type="checkbox"/> IV Drugs-Current <input type="checkbox"/> Other: <input type="checkbox"/> IV Drugs-Past Hx

Name: _____ DOB: _____ MR#: _____

Family History	<input type="checkbox"/> Unremarkable <input type="checkbox"/> Diabetes
<input type="checkbox"/> Heart disease / HTN	<input type="checkbox"/> Lives/lived with someone HBV+ <input type="checkbox"/> Asthma
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Cancer <input type="checkbox"/> Family Hx of unexpected or sudden death < 50 yrs
<input type="checkbox"/> Anemia	<input type="checkbox"/> Other:
Dyadic Behavioral / Social Determinants of Health (SDOH)	<input type="checkbox"/> WNL - Stable relationships w/ social/emotional support <input type="checkbox"/> Changes in family since last visit (move, job, death) <input type="checkbox"/> Problems with housing, food, employment, incarceration <input type="checkbox"/> Family stressors (mental illness, drugs, violence/abuse)
Lives with	<input type="checkbox"/> 1 Parent <input type="checkbox"/> 2 Parents <input type="checkbox"/> Other:
AAP Risk Screener	Screening Tools Used Low Risk High Risk (see Plan/Orders/AG)
Adverse Childhood Experiences	<input type="checkbox"/> PEARLS , <input type="checkbox"/> Other: <input type="checkbox"/>
Alcohol Misuse	<input type="checkbox"/> SHA , <input type="checkbox"/> CRAFFT , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: <input type="checkbox"/>
Anemia	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: <input type="checkbox"/>
Dental (cavities, no dental home)	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: <input type="checkbox"/>
Depression Score: _____	<input type="checkbox"/> PHQ-9A , <input type="checkbox"/> Other: <input type="checkbox"/>
Drug Misuse	<input type="checkbox"/> SHA , <input type="checkbox"/> CRAFFT , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: <input type="checkbox"/>
Dyadic Behavioral / SDOH	<input type="checkbox"/> SDOH , <input type="checkbox"/> PEARLS , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: <input type="checkbox"/>
Dyslipidemia	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: <input type="checkbox"/>
Hepatitis B	<input type="checkbox"/> CDC HEP Risk , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: <input type="checkbox"/>
HIV (Test at least once starting at 15 yrs old)	<input type="checkbox"/> SHA , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: <input type="checkbox"/>
Sexually Transmitted Infections	<input type="checkbox"/> SHA , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: <input type="checkbox"/>
Sudden Cardiac Arrest	<input type="checkbox"/> SCD , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: <input type="checkbox"/>
Suicide	<input type="checkbox"/> ASQ , <input type="checkbox"/> PHQ-9A , <input type="checkbox"/> Other: <input type="checkbox"/>
Tobacco Use / Exposure	<input type="checkbox"/> SHA , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: <input type="checkbox"/>
Tuberculosis Exposure	<input type="checkbox"/> TB Risk Assessment , <input type="checkbox"/> Other: <input type="checkbox"/>
Growth and Development / School Progress Grade: _____	
<input type="checkbox"/> School achievement	<input type="checkbox"/> Performs chores <input type="checkbox"/> Plays / listens to music
<input type="checkbox"/> School attendance	<input type="checkbox"/> Learns new skills <input type="checkbox"/> Reads
<input type="checkbox"/> Understands parental limits & consequences for unacceptable behavior	<input type="checkbox"/> Participates in organized sports / social activities <input type="checkbox"/> Uses both hands independently
<input type="checkbox"/> Ability to get along with peers	<input type="checkbox"/> Learns from mistakes & failures, tries again <input type="checkbox"/> Preoccupation with rapid body changes
Physical Examination WNL	
General appearance	Well-nourished & developed No abuse/neglect evident <input type="checkbox"/>
Head	No lesions <input type="checkbox"/>
Eyes	PERRLA, conjunctivae & sclerae clear Vision grossly normal <input type="checkbox"/>

Comprehensive Health Assessment

Ears	Canals clear, TMs normal Hearing grossly normal	<input type="checkbox"/>
Nose	Passages clear, MM pink, no lesions	<input type="checkbox"/>
Teeth	No visible cavities, grossly normal	<input type="checkbox"/>
Mouth / Pharynx	Oral mucosa pink, no lesions	<input type="checkbox"/>
Neck	Supple, no masses, thyroid not enlarged	<input type="checkbox"/>
Chest/Breast (females)	Symmetrical, no masses Tanner stage: I II III IV V	<input type="checkbox"/>
Heart	No organic murmurs, regular rhythm	<input type="checkbox"/>
Lungs	Clear to auscultation bilaterally	<input type="checkbox"/>
Abdomen	Soft, no masses, liver & spleen normal	<input type="checkbox"/>
Genitalia	Grossly normal Tanner stage: I II III IV V	<input type="checkbox"/>
Male	Circ / uncircumcised, testes in scrotum	<input type="checkbox"/>
Female	No lesions, normal external appearance	<input type="checkbox"/>
Femoral pulses	Normal	<input type="checkbox"/>
Extremities	No deformities, full ROM	<input type="checkbox"/>
Lymph nodes	Not enlarged	<input type="checkbox"/>
Back	No scoliosis	<input type="checkbox"/>
Skin	Clear, no significant lesions	<input type="checkbox"/>
Neurologic	Alert, no gross sensory or motor deficit	<input type="checkbox"/>
Subjective / Objective		
Assessment		
Plan		
Referrals		
<input type="checkbox"/> Dentist	<input type="checkbox"/> Optometrist / Ophthalmologist	<input type="checkbox"/> Dietician / Nutritionist
<input type="checkbox"/> Drug / ETOH Tx rehab	<input type="checkbox"/> Behavioral health	<input type="checkbox"/> Tobacco cessation class
<input type="checkbox"/> CA Children's Services (CCS)	<input type="checkbox"/> Regional Center	<input type="checkbox"/> Early Start or Local Education Agency
<input type="checkbox"/> OB/GYN:	<input type="checkbox"/> Other:	
Orders		
<input type="checkbox"/> COVID 19 vaccine	<input type="checkbox"/> Tdap	<input type="checkbox"/> CBC / Basic metabolic panel
<input type="checkbox"/> Hep B vaccine (if not up to date)	<input type="checkbox"/> Varicella (if not up to date)	<input type="checkbox"/> Hct / Hgb (yearly if menstruating)
<input type="checkbox"/> HPV vaccine (if not up to date)	<input type="checkbox"/> Hep B Panel (if high risk)	<input type="checkbox"/> Lipid panel (if high risk)
<input type="checkbox"/> Influenza vaccine	<input type="checkbox"/> Chlamydia <input type="checkbox"/> Gonorrhea	<input type="checkbox"/> PPD skin test <input type="checkbox"/> QFT
<input type="checkbox"/> Meningococcal vaccine (if not up to date)	<input type="checkbox"/> HIV (if high risk) <input type="checkbox"/> Herpes	<input type="checkbox"/> CXR <input type="checkbox"/> Urinalysis
<input type="checkbox"/> MMR (if not up to date)	<input type="checkbox"/> Syphilis <input type="checkbox"/> Trichomonas	<input type="checkbox"/> ECG <input type="checkbox"/> COVID 19 test
<input type="checkbox"/> Rx Fluoride drops / chewable tabs (0.50 mg/1.0 mg QD)	<input type="checkbox"/> Other:	

Name: _____ DOB: _____ MR#: _____

Anticipatory Guidance (AG) / Education (✓ if discussed)		
Health education preference: <input type="checkbox"/> Verbal <input type="checkbox"/> Visual <input type="checkbox"/> Multimedia <input type="checkbox"/> Other:		
Diet, Nutrition & Exercise		
<input type="checkbox"/> Weight control / obesity	<input type="checkbox"/> Vegetables, fruits	<input type="checkbox"/> Lean protein
<input type="checkbox"/> Whole grains / iron-rich foods	<input type="checkbox"/> Limit fatty, sugary & salty foods	<input type="checkbox"/> Limit candy, chips & ice cream
<input type="checkbox"/> Physical activity / exercise	<input type="checkbox"/> Healthy food choices	<input type="checkbox"/> Eating disorder
Accident Prevention & Guidance		
<input type="checkbox"/> Alcohol/drug/substance misuse counseling	<input type="checkbox"/> Social Media Use	<input type="checkbox"/> Goals in life
<input type="checkbox"/> Signs of depression (suicidal ideation)	<input type="checkbox"/> Avoid risk-taking behavior	<input type="checkbox"/> Independence
<input type="checkbox"/> Mental health (emotional support)	<input type="checkbox"/> Gun safety	<input type="checkbox"/> Personal development
<input type="checkbox"/> Intimate partner violence	<input type="checkbox"/> Violent behavior	<input type="checkbox"/> Academic or work plans
<input type="checkbox"/> Sex education (partner selection)	<input type="checkbox"/> Safety helmet	<input type="checkbox"/> Family support, social interaction & communication
<input type="checkbox"/> Safe sex practices (condoms, contraception, HIV/AIDS)	<input type="checkbox"/> Seat belt	<input type="checkbox"/> Mindful of daily movements
<input type="checkbox"/> Skin cancer prevention	<input type="checkbox"/> Motor vehicle safety (no texting & driving)	<input type="checkbox"/> Physical growth
<input type="checkbox"/> Smoking/vaping use/exposure	<input type="checkbox"/> Routine dental care	<input type="checkbox"/> Sexuality
Tobacco Use / Cessation Exposed to 2 nd hand smoke <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Never smoked or used tobacco products		
<input type="checkbox"/> Former smoker: # Yrs smoked ____ # Cigarettes smoked/day ____ Quit date ____		
<input type="checkbox"/> Current smoker: # Yrs smoked ____ # Cigarettes smoked/day ____		
Type used: <input type="checkbox"/> Cigarettes <input type="checkbox"/> Chewing tobacco <input type="checkbox"/> Vaping products <input type="checkbox"/> Other:		
<input type="checkbox"/> Advised to quit smoking	<input type="checkbox"/> Discussed smoking cessation medication	<input type="checkbox"/> Discussed smoking cessation strategies
Next Appointment		
<input type="checkbox"/> 1 year	<input type="checkbox"/> RTC PRN	<input type="checkbox"/> Other:

Documentation Reminders		
<input type="checkbox"/> Screening tools (TB, Depression/Suicide, HEP B, etc.) are completed, dated, & reviewed by provider	<input type="checkbox"/> Height / Weight / BMI measurements plotted in CDC growth chart	<input type="checkbox"/> Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date
Provider Signature	Title	Date

Notes (include date, time, signature, and title on all entries)
<input type="checkbox"/> Member/parent refused the following screening/orders:

Comprehensive Health Assessment

17 to 20 Years	Actual Age: _____ Date: _____
Sex at Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female
Accompanied By	<input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Other: _____
Primary Language	_____
Interpreter Requested	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused Name of Interpreter: _____
Intake	(See CDC Growth Chart) Vital Signs
Height	Temp _____
Weight <input type="checkbox"/> Significant loss/gain: _____ lbs	BP _____
BMI Value	Pulse _____
BMI %	Resp _____
Allergies / Reaction	_____
Pain	Location: _____ Scale: 0 1 2 3 4 5 6 7 8 9 10
Hearing Screening	<input type="checkbox"/> Responded at ≤ 25 dB at 1000-8000 frequencies in both ears <input type="checkbox"/> Non coop
Vision Screening	OD: _____ OS: _____ OU: _____ <input type="checkbox"/> Non coop
Cultural Needs (e.g., cultural background/traditions, religious practices, dietary preference/restrictions, and healthcare beliefs): <input type="checkbox"/> Unremarkable	
Country of Birth: <input type="checkbox"/> US <input type="checkbox"/> Other: _____ At least 1 parent born in Africa, Asia, Pacific Islands: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Dental Home	Dental visit within past 12 months: <input type="checkbox"/> Yes <input type="checkbox"/> No
<u>Advance Directive</u> Info given/discussed	<input type="checkbox"/> Yes <input type="checkbox"/> Refused Starting at 18 years old
Chronic Problems/Significant Conditions: <input type="checkbox"/> None <input type="checkbox"/> See Problem List <input type="checkbox"/> Asthma <input type="checkbox"/> Cancer <input type="checkbox"/> Depression <input type="checkbox"/> DM <input type="checkbox"/> Dialysis <input type="checkbox"/> Heart Disease <input type="checkbox"/> HEP B <input type="checkbox"/> HEP C <input type="checkbox"/> High Cholesterol <input type="checkbox"/> HIV <input type="checkbox"/> HTN <input type="checkbox"/> Liver Disease <input type="checkbox"/> Seizures <input type="checkbox"/> STI <input type="checkbox"/> Uses DME <input type="checkbox"/> ≥ 2 ER visits in 12 months <input type="checkbox"/> Other: _____	
Functional Limitations (check all that apply): <input type="checkbox"/> Unremarkable <input type="checkbox"/> Seeing <input type="checkbox"/> Hearing <input type="checkbox"/> Mobility <input type="checkbox"/> Communication <input type="checkbox"/> Cognition <input type="checkbox"/> Self-care	
Current Medications/Vitamins: <input type="checkbox"/> See Medication List <input type="checkbox"/> Taking 0.4 to 0.8 mg of folic acid daily (females of reproductive age)	
Interval History	
Diet / Nutrition	<input type="checkbox"/> Regular <input type="checkbox"/> Low calorie <input type="checkbox"/> ADA <input type="checkbox"/> Iron-rich foods <input type="checkbox"/> Other: _____
Appetite	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
Physical Activity	<input type="checkbox"/> Inactive (little or none) <input type="checkbox"/> Some (< 2 1/2 hrs/week) <input type="checkbox"/> Active (≥ 60 min/day) <input type="checkbox"/> Fainting <input type="checkbox"/> Sudden seizures <input type="checkbox"/> SOB <input type="checkbox"/> Chest pain
Vaccines Up to Date	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> See CAIR
Sexually Active	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Multiple Partners <input type="checkbox"/> MSM
Contraceptive Used	<input type="checkbox"/> None <input type="checkbox"/> Condoms <input type="checkbox"/> Other: _____
LMP (females):	G P A <input type="checkbox"/> Menorrhagia
Current Alcohol / Substance Use	<input type="checkbox"/> None <input type="checkbox"/> Alcohol
<input type="checkbox"/> Drugs (specify):	<input type="checkbox"/> IV Drugs-Current <input type="checkbox"/> Other: _____ <input type="checkbox"/> IV Drugs-Past Hx

Name: _____ DOB: _____ MR#: _____

Family History	<input type="checkbox"/> Unremarkable <input type="checkbox"/> Diabetes
<input type="checkbox"/> Heart disease / HTN	<input type="checkbox"/> Lives/lived with someone HBV+ <input type="checkbox"/> Asthma
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Cancer <input type="checkbox"/> Family Hx of unexpected or sudden death < 50 yrs
<input type="checkbox"/> Anemia	<input type="checkbox"/> Other: _____
Dyadic Behavioral / Social Determinants of Health (SDOH)	<input type="checkbox"/> WNL - Stable relationships w/ social/emotional support <input type="checkbox"/> Changes in family since last visit (move, job, death) <input type="checkbox"/> Problems with housing, food, employment, incarceration <input type="checkbox"/> Family stressors (mental illness, drugs, violence/abuse)
Lives with	<input type="checkbox"/> 1 Parent <input type="checkbox"/> 2 Parents <input type="checkbox"/> Other: _____
AAP Risk Screener	Screening Tools Used Low Risk High Risk (see Plan/Orders/AG)
Adverse Childhood Experiences	<input type="checkbox"/> ACEs , <input type="checkbox"/> PEARLS , <input type="checkbox"/> Other: _____
Alcohol Misuse	<input type="checkbox"/> SHA , <input type="checkbox"/> CRAFFT , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____
Anemia	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____
Dental (cavities, no dental home)	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____
Depression Score: _____	<input type="checkbox"/> PHQ-9A , <input type="checkbox"/> Other: _____
Drug Misuse	<input type="checkbox"/> SHA , <input type="checkbox"/> CRAFFT , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____
Dyadic Behavioral / SDOH	<input type="checkbox"/> SDOH , <input type="checkbox"/> PEARLS , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____
Dyslipidemia	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____
Hep B (Test all 18 yrs and older at least once at earliest opportunity)	<input type="checkbox"/> CDC HEP Risk , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____
Hep C (Test all 18-79 yrs old at least once at earliest opportunity)	<input type="checkbox"/> CDC HEP Risk , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____
HIV (Test all 15-65 yrs old at least once at earliest opportunity)	<input type="checkbox"/> SHA , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____
Sexually Transmitted Infections	<input type="checkbox"/> SHA , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____
Sudden Cardiac Arrest	<input type="checkbox"/> SCD , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____
Suicide	<input type="checkbox"/> ASQ , <input type="checkbox"/> PHQ-9A , <input type="checkbox"/> Other: _____
Tobacco Use / Exposure	<input type="checkbox"/> SHA , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____
Tuberculosis Exposure	<input type="checkbox"/> TB Risk Assessment , <input type="checkbox"/> Other: _____
Growth and Development / School Progress Grade: _____	
<input type="checkbox"/> Hobbies / work	<input type="checkbox"/> Plays sports <input type="checkbox"/> Plays / listens to music
<input type="checkbox"/> School achievement / attendance	<input type="checkbox"/> Acts responsibly for self <input type="checkbox"/> Takes on new responsibility
<input type="checkbox"/> Improved social skills; maintains family relationships	<input type="checkbox"/> Sets goals & works towards achieving them <input type="checkbox"/> Preparation for further education, career, marriage & parenting
Physical Examination WNL	
General appearance	Well-nourished & developed No abuse/neglect evident <input type="checkbox"/>
Head	No lesions <input type="checkbox"/>
Eyes	PERRLA, conjunctivae & sclerae clear Vision grossly normal <input type="checkbox"/>

Comprehensive Health Assessment

Ears	Canals clear, TMs normal Hearing grossly normal	<input type="checkbox"/>
Nose	Passages clear, MM pink, no lesions	<input type="checkbox"/>
Teeth	No visible cavities, grossly normal	<input type="checkbox"/>
Mouth / Pharynx	Oral mucosa pink, no lesions	<input type="checkbox"/>
Neck	Supple, no masses, thyroid not enlarged	<input type="checkbox"/>
Chest / Breast (females)	Symmetrical, no masses Tanner stage: I II III IV V	<input type="checkbox"/>
Heart	No organic murmurs, regular rhythm	<input type="checkbox"/>
Lungs	Clear to auscultation bilaterally	<input type="checkbox"/>
Abdomen	Soft, no masses, liver & spleen normal	<input type="checkbox"/>
Genitalia	Grossly normal Tanner stage: I II III IV V	<input type="checkbox"/>
Male	Circ / uncircumcised, testes in scrotum	<input type="checkbox"/>
Female	No lesions, normal external appearance	<input type="checkbox"/>
Vaginal exam	Done or completed elsewhere OB/GYN name:	<input type="checkbox"/>
Femoral pulses	Normal	<input type="checkbox"/>
Lymph nodes	Not enlarged	<input type="checkbox"/>
Back	No scoliosis	<input type="checkbox"/>
Skin	Clear, no significant lesions	<input type="checkbox"/>
Neurologic	Alert, no gross sensory or motor deficit	<input type="checkbox"/>
Subjective / Objective		
Assessment		
Plan		
Referrals		
<input type="checkbox"/> Dentist	<input type="checkbox"/> Optometrist/ Ophthalmologist	<input type="checkbox"/> Dietician/ Nutritionist
<input type="checkbox"/> Drug / ETOH Tx rehab	<input type="checkbox"/> Behavioral health	<input type="checkbox"/> Tobacco cessation class
<input type="checkbox"/> CA Children's Services (CCS)	<input type="checkbox"/> Regional Center	<input type="checkbox"/> Early Start or Local Education Agency
<input type="checkbox"/> OB/GYN	<input type="checkbox"/> Other:	
Orders		
<input type="checkbox"/> COVID 19 vaccine	<input type="checkbox"/> Hep B Panel (at least once \geq 18 yrs)	<input type="checkbox"/> CBC / Basic metabolic panel
<input type="checkbox"/> Hep B vaccine (if not up to date)	<input type="checkbox"/> Hep C Antibody test (at least once \geq 18 yrs)	<input type="checkbox"/> Hct / Hgb (yearly if menstruating)
<input type="checkbox"/> HPV vaccine (if not up to date)	<input type="checkbox"/> Rx for folic acid 0.4-0.8mg daily (females)	<input type="checkbox"/> Lipid panel (once between 17-21 yrs)
<input type="checkbox"/> Influenza vaccine	<input type="checkbox"/> Chlamydia	<input type="checkbox"/> PPD skin test
	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> QFT
<input type="checkbox"/> Meningococcal vaccine (if not up to date)	<input type="checkbox"/> HIV (if high risk)	<input type="checkbox"/> CXR
	<input type="checkbox"/> Herpes	<input type="checkbox"/> Urinalysis
<input type="checkbox"/> MMR (if not up to date)	<input type="checkbox"/> Syphilis	<input type="checkbox"/> ECG
	<input type="checkbox"/> Trichomonas	<input type="checkbox"/> COVID 19 test
<input type="checkbox"/> Tdap	<input type="checkbox"/> Other:	

Name: _____ DOB: _____ MR#: _____

Anticipatory Guidance (AG) / Education (✓ if discussed)		
Health education preference: <input type="checkbox"/> Verbal <input type="checkbox"/> Visual <input type="checkbox"/> Multimedia <input type="checkbox"/> Other:		
Diet, Nutrition & Exercise		
<input type="checkbox"/> Weight control / obesity	<input type="checkbox"/> Vegetables, fruits	<input type="checkbox"/> Lean protein
<input type="checkbox"/> Whole grains / iron-rich foods	<input type="checkbox"/> Limit fatty, sugary & salty foods	<input type="checkbox"/> Limit candy, chips & ice cream
<input type="checkbox"/> Physical activity / exercise	<input type="checkbox"/> Healthy food choices	<input type="checkbox"/> Eating disorder
Accident Prevention & Guidance		
<input type="checkbox"/> Alcohol/drug/substance misuse counseling	<input type="checkbox"/> Social media use	<input type="checkbox"/> Transitioning to adult provider
<input type="checkbox"/> Routine dental care	<input type="checkbox"/> Avoid risk-taking behavior	<input type="checkbox"/> Independence
<input type="checkbox"/> Signs of depression (suicidal ideation)	<input type="checkbox"/> Gun safety	<input type="checkbox"/> Personal development & goals in life
<input type="checkbox"/> Intimate partner violence	<input type="checkbox"/> Violent behavior	<input type="checkbox"/> Academic or work plans
<input type="checkbox"/> Safe sex practices (condoms, contraception, HIV/AIDS)	<input type="checkbox"/> Seat belt / Safety Helmet	<input type="checkbox"/> Testicular self-exam
<input type="checkbox"/> Skin cancer prevention	<input type="checkbox"/> Motor vehicle safety (no texting & driving)	<input type="checkbox"/> Self-breast exam
<input type="checkbox"/> Smoking/vaping use/exposure	<input type="checkbox"/> Mental health (emotional support)	<input type="checkbox"/> Prenatal care / encourage breastfeeding
Tobacco Use / Cessation Exposed to 2 nd hand smoke <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Never smoked or used tobacco products		
<input type="checkbox"/> Former smoker: # Yrs smoked ____ # Cigarettes smoked/day ____ Quit date ____		
<input type="checkbox"/> Current smoker: # Yrs smoked ____ # Cigarettes smoked/day ____		
Type used: <input type="checkbox"/> Cigarettes <input type="checkbox"/> Chewing tobacco <input type="checkbox"/> Vaping products <input type="checkbox"/> Other:		
<input type="checkbox"/> Advised to quit smoking	<input type="checkbox"/> Discussed smoking cessation medication	<input type="checkbox"/> Discussed smoking cessation strategies
Next Appointment		
<input type="checkbox"/> 1 year	<input type="checkbox"/> RTC PRN	<input type="checkbox"/> Other:

Documentation Reminders		
<input type="checkbox"/> Screening tools (TB, Depression/Suicide, HEP B, etc.) are completed, dated, & reviewed by provider	<input type="checkbox"/> Height / Weight / BMI measurements plotted in CDC growth chart	<input type="checkbox"/> Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date
Provider Signature	Title	Date

Notes (include date, time, signature, and title on all entries)
<input type="checkbox"/> Member/parent refused the following screening/orders:

Comprehensive Health Assessment

21 to 39 Years: Female at Birth	Actual Age: _____	Date: _____
Primary Language		
Interpreter Requested	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused Name of Interpreter: _____	
Intake	Vital Signs	
Allergies / Reaction	Temp	
Height	BP	
Weight <input type="checkbox"/> Significant loss/gain: _____ lbs	Pulse	
BMI Value	Resp	
Pain	Location: _____ Scale: 0 1 2 3 4 5 6 7 8 9 10	
Cultural Needs (e.g., cultural background/traditions, religious practices, dietary preference/restrictions, and healthcare beliefs): _____ <input type="checkbox"/> Unremarkable		
Country of Birth: <input type="checkbox"/> US <input type="checkbox"/> Other: _____ At least 1 parent born in Africa, Asia, Pacific Islands: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Dental Home	Dental visit within past 12 months: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Advance Directive Info Given/Discussed	<input type="checkbox"/> Yes <input type="checkbox"/> Refused	
Chronic Problems/Significant Conditions: <input type="checkbox"/> None <input type="checkbox"/> See Problem List <input type="checkbox"/> Asthma <input type="checkbox"/> Cancer <input type="checkbox"/> Depression <input type="checkbox"/> DM <input type="checkbox"/> Dialysis <input type="checkbox"/> Heart Disease <input type="checkbox"/> HEP B <input type="checkbox"/> HEP C <input type="checkbox"/> High Cholesterol <input type="checkbox"/> HIV <input type="checkbox"/> HTN <input type="checkbox"/> Liver Disease <input type="checkbox"/> Seizures <input type="checkbox"/> STI <input type="checkbox"/> Uses DME <input type="checkbox"/> ≥ 2 ER visits in 12 months <input type="checkbox"/> Other: _____		
Functional Limitations (check all that apply): <input type="checkbox"/> Unremarkable <input type="checkbox"/> Seeing <input type="checkbox"/> Hearing <input type="checkbox"/> Mobility <input type="checkbox"/> Communication <input type="checkbox"/> Cognition <input type="checkbox"/> Self-care		
Current Medications/Vitamins: <input type="checkbox"/> See Medication List <input type="checkbox"/> taking 0.4 to 0.8 mg of folic acid daily (for reproductive females)		
Education (last grade completed): _____ Health education preference: <input type="checkbox"/> Verbal <input type="checkbox"/> Visual <input type="checkbox"/> Multimedia <input type="checkbox"/> Other: _____		
Interval History		
Diet / Nutrition	<input type="checkbox"/> Regular <input type="checkbox"/> Low calorie <input type="checkbox"/> ADA <input type="checkbox"/> Iron-rich foods <input type="checkbox"/> Other: _____	
Appetite	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
Physical Activity	<input type="checkbox"/> Inactive (little or none) <input type="checkbox"/> Some (< 2 ½ hrs/week) <input type="checkbox"/> Active (≥ 2 ½ hrs per week w/ 2 days strength training)	
LMP: <input type="checkbox"/> Pregnant	G P A	<input type="checkbox"/> Menorrhagia
Sexually Active	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Multiple Partners	
Contraceptive Used	<input type="checkbox"/> None <input type="checkbox"/> Condoms <input type="checkbox"/> Other: _____	
Social Determinants of Health (SDOH)	Intimate Partner Violence (IPV) in the last 12 months: Has anyone physically hurt you? <input type="checkbox"/> Yes <input type="checkbox"/> No Has anyone insulted or humiliated you? <input type="checkbox"/> Yes <input type="checkbox"/> No Has anyone threatened you? <input type="checkbox"/> Yes <input type="checkbox"/> No Has anyone screamed or cursed at you? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Last PAP/HPV	Date: _____	<input type="checkbox"/> WNL
Current Alcohol / Substance Use	<input type="checkbox"/> None	<input type="checkbox"/> Alcohol
<input type="checkbox"/> Drugs (specify): _____	<input type="checkbox"/> IV Drugs-Current <input type="checkbox"/> IV Drugs-Past Hx	<input type="checkbox"/> Other: _____

Name:	DOB:	MR#:	
Family History	<input type="checkbox"/> None	<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Heart disease / HTN	<input type="checkbox"/> Lives/lived with someone HBV+	<input type="checkbox"/> Hip fracture	
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Cancer	<input type="checkbox"/> Other: _____	
Immunization History and Dates	<input type="checkbox"/> None	<input type="checkbox"/> See CAIR	
<input type="checkbox"/> COVID #1: <input type="checkbox"/> COVID #2:	<input type="checkbox"/> Influenza:	<input type="checkbox"/> Tdap:	
<input type="checkbox"/> COVID Booster(s):	<input type="checkbox"/> MMR:	<input type="checkbox"/> Varicella:	
<input type="checkbox"/> Hepatitis B:	<input type="checkbox"/> Pneumococcal:	<input type="checkbox"/> Other: _____	
USPSTF Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/Orders/AG)
Adverse Childhood Experiences (screen at least once in adulthood at earliest opportunity)	<input type="checkbox"/> ACEs	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol Misuse	<input type="checkbox"/> SHA , <input type="checkbox"/> CRAFFT , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Cervical Cancer	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Depression Score: _____	<input type="checkbox"/> PHQ2 , <input type="checkbox"/> PHQ9 , <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Drug Misuse	<input type="checkbox"/> SHA , <input type="checkbox"/> CRAFFT , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Dyslipidemia	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Hep B (Test all 18 yrs and older at least once at earliest opportunity)	<input type="checkbox"/> CDC HEP Risk , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Hep C (Test all 18-79 yrs old at least once at earliest opportunity)	<input type="checkbox"/> CDC HEP Risk , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
HIV (Test all 15-65 yrs old at least once at earliest opportunity)	<input type="checkbox"/> SHA , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Obesity	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Sexually Transmitted Infections	<input type="checkbox"/> SHA , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
SDOH / Intimate Partner Violence	<input type="checkbox"/> SDOH , <input type="checkbox"/> HITS , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco Use	<input type="checkbox"/> SHA , <input type="checkbox"/> CRAFFT , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis Exposure	<input type="checkbox"/> TB Risk Assessment , <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Physical Examination		WNL	
General appearance	Well-nourished & developed No abuse/neglect evident	<input type="checkbox"/>	
Head	No lesions	<input type="checkbox"/>	
Eyes	PERRLA, conjunctivae & sclerae clear, Vision grossly normal	<input type="checkbox"/>	
Ears	Canals clear, TMs normal Hearing grossly normal	<input type="checkbox"/>	
Nose	Passages clear, MM pink, no lesions	<input type="checkbox"/>	
Teeth	No visible cavities, grossly normal	<input type="checkbox"/>	
Mouth / Pharynx	Oral mucosa pink, no lesions	<input type="checkbox"/>	
Neck	Supple, no masses, thyroid not enlarged	<input type="checkbox"/>	
Chest / Breast	Symmetrical, no masses	<input type="checkbox"/>	

Comprehensive Health Assessment

Heart	No organic murmurs, regular rhythm	<input type="checkbox"/>
Lungs	Clear to auscultation bilaterally	<input type="checkbox"/>
Abdomen	Soft, no masses, liver & spleen normal	<input type="checkbox"/>
Genitalia	Grossly normal	<input type="checkbox"/>
Female	No lesions, normal external appearance	<input type="checkbox"/>
Vaginal exam	Done or completed elsewhere OB/GYN name:	<input type="checkbox"/>
Femoral pulses	Present & equal	<input type="checkbox"/>
Extremities	No deformities, full ROM	<input type="checkbox"/>
Lymph nodes	Not enlarged	<input type="checkbox"/>
Back	No scoliosis	<input type="checkbox"/>
Skin	Clear, no significant lesions	<input type="checkbox"/>
Neurologic	Alert, no gross sensory or motor deficit	<input type="checkbox"/>

Subjective / Objective

Assessment

Plan

Referrals

<input type="checkbox"/> Dentist	<input type="checkbox"/> Optometrist / Ophthalmologist	<input type="checkbox"/> Dietician / Nutritionist
<input type="checkbox"/> Drug / ETOH Tx rehab	<input type="checkbox"/> Behavioral health	<input type="checkbox"/> Tobacco cessation class
<input type="checkbox"/> OB/GYN:	<input type="checkbox"/> Other:	

Orders

<input type="checkbox"/> COVID 19 vaccine / booster	<input type="checkbox"/> Varicella (if not up to date)	<input type="checkbox"/> CBC / Basic metabolic panel
<input type="checkbox"/> Hep B vaccine (if not up to date)	<input type="checkbox"/> Hep B Panel (if high risk)	<input type="checkbox"/> Hct / Hgb <input type="checkbox"/> Lipid panel
<input type="checkbox"/> HPV vaccine (if not up to date)	<input type="checkbox"/> Hep C Antibody test (if high risk)	<input type="checkbox"/> Low to moderate dose statin
<input type="checkbox"/> Influenza vaccine	<input type="checkbox"/> Chlamydia <input type="checkbox"/> Gonorrhea	<input type="checkbox"/> PPD skin test <input type="checkbox"/> QFT
<input type="checkbox"/> Meningococcal vaccine (if not up to date)	<input type="checkbox"/> HIV (if high risk) <input type="checkbox"/> Herpes	<input type="checkbox"/> CXR <input type="checkbox"/> Urinalysis
<input type="checkbox"/> MMR (if not up to date)	<input type="checkbox"/> Syphilis <input type="checkbox"/> Trichomonas	<input type="checkbox"/> ECG <input type="checkbox"/> COVID 19 test
<input type="checkbox"/> Pneumococcal (if high risk)	<input type="checkbox"/> Rx for folic acid 0.4-0.8mg daily	<input type="checkbox"/> Fasting plasma glucose / HbA1C
<input type="checkbox"/> Tdap	<input type="checkbox"/> Bone Density Test	<input type="checkbox"/> PAP <input type="checkbox"/> HPV
<input type="checkbox"/> Other:		

Name: _____ DOB: _____ MR#: _____

Anticipatory Guidance (AG) / Education (✓ if discussed)

Diet, Nutrition & Exercise

<input type="checkbox"/> Weight control / obesity	<input type="checkbox"/> Vegetables, fruits	<input type="checkbox"/> Lean protein
<input type="checkbox"/> Whole grains / iron-rich foods	<input type="checkbox"/> Limit fatty, sugary & salty foods	<input type="checkbox"/> Limit candy, chips & ice cream
<input type="checkbox"/> Physical activity / exercise	<input type="checkbox"/> Healthy food choices	<input type="checkbox"/> Eating disorder

Accident Prevention & Guidance

<input type="checkbox"/> Alcohol/drug/substance misuse counseling	<input type="checkbox"/> Avoid risk-taking behavior	<input type="checkbox"/> Independence
<input type="checkbox"/> Routine dental care	<input type="checkbox"/> Gun safety	<input type="checkbox"/> Personal development
<input type="checkbox"/> Signs of depression (suicidal ideation)	<input type="checkbox"/> Violent behavior	<input type="checkbox"/> Goals in life
<input type="checkbox"/> Intimate partner violence	<input type="checkbox"/> Mindful of daily movements	<input type="checkbox"/> Family support, social interaction & communication
<input type="checkbox"/> Diabetes management	<input type="checkbox"/> Motor vehicle safety (DUI / no texting & driving)	<input type="checkbox"/> Academic or work plans
<input type="checkbox"/> Safe sex practices (condoms, contraception, HIV/AIDS)	<input type="checkbox"/> Seat belt	<input type="checkbox"/> Self-breast exam
<input type="checkbox"/> Skin cancer prevention	<input type="checkbox"/> Safety helmet	<input type="checkbox"/> Breastfeeding
<input type="checkbox"/> Smoking/vaping use/exposure	<input type="checkbox"/> ASA use	<input type="checkbox"/> Sex education (partner selection)

Tobacco Use / Cessation

Never smoked or used tobacco products

Former smoker: # Yrs smoked ____ # Cigarettes smoked/day ____ Quit date ____

Current smoker: # Yrs smoked ____ # Cigarettes smoked/day ____

Type used: Cigarettes Chewing tobacco Vaping products Other:

Advised to quit smoking Discussed smoking cessation medication Discussed smoking cessation strategies

Next Appointment

<input type="checkbox"/> 1 year	<input type="checkbox"/> RTC PRN	<input type="checkbox"/> Other:
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Documentation Reminders

<input type="checkbox"/> Screening tools (TB, Depression, HEP B, etc.) are completed, dated, & reviewed by provider	<input type="checkbox"/> Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)	<input type="checkbox"/> Problem / Medication Lists updated
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MA / Nurse Signature	Title	Date
Provider Signature	Title	Date

Notes (include date, time, signature, and title on all entries)

Member refused the following screening/orders:

Comprehensive Health Assessment

21 to 39 Years: Male at Birth	Actual Age: _____	Date: _____
Primary Language	_____	
Interpreter Requested	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused Name of Interpreter: _____	
Intake	Vital Signs	
Allergies / Reaction	Temp	_____
Height	BP	_____
Weight <small>□ Significant loss/gain: ___ lbs</small>	Pulse	_____
BMI Value	Resp	_____
Pain	Location: _____ Scale: 0 1 2 3 4 5 6 7 8 9 10	
Cultural Needs (e.g., cultural background/traditions, religious practices, dietary preference/restrictions, and healthcare beliefs): _____ <input type="checkbox"/> Unremarkable		
Country of Birth: <input type="checkbox"/> US <input type="checkbox"/> Other: _____ At least 1 parent born in Africa, Asia, Pacific Islands: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Dental Home	Dental visit within past 12 months: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Advance Directive Info given/discussed	<input type="checkbox"/> Yes <input type="checkbox"/> Refused	
Chronic Problems/Significant Conditions: <input type="checkbox"/> None <input type="checkbox"/> See Problem List <input type="checkbox"/> Asthma <input type="checkbox"/> Cancer <input type="checkbox"/> Depression <input type="checkbox"/> DM <input type="checkbox"/> Dialysis <input type="checkbox"/> Heart Disease <input type="checkbox"/> HEP B <input type="checkbox"/> HEP C <input type="checkbox"/> High Cholesterol <input type="checkbox"/> HIV <input type="checkbox"/> HTN <input type="checkbox"/> Liver Disease <input type="checkbox"/> Seizures <input type="checkbox"/> STI <input type="checkbox"/> Uses DME <input type="checkbox"/> ≥ 2 ER visits in 12 months <input type="checkbox"/> Other: _____		
Functional Limitations (check all that apply): <input type="checkbox"/> Unremarkable <input type="checkbox"/> Seeing <input type="checkbox"/> Hearing <input type="checkbox"/> Mobility <input type="checkbox"/> Communication <input type="checkbox"/> Cognition <input type="checkbox"/> Self-care		
Current Medications/Vitamins: <input type="checkbox"/> See Medication List		
Education (last grade completed): _____ Health education preference: <input type="checkbox"/> Verbal <input type="checkbox"/> Visual <input type="checkbox"/> Multimedia <input type="checkbox"/> Other: _____		
Interval History		
Diet / Nutrition	<input type="checkbox"/> Regular <input type="checkbox"/> Low calorie <input type="checkbox"/> ADA <input type="checkbox"/> Iron-rich foods <input type="checkbox"/> Other: _____	
Appetite	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
Physical Activity	<input type="checkbox"/> Inactive (little or none) <input type="checkbox"/> Some (< 2 ½ hrs/week) <input type="checkbox"/> Active (≥ 2 ½ hrs per week w/ 2 days strength training)	
Sexually Active	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Multiple Partners <input type="checkbox"/> MSM	
Contraceptive Used	<input type="checkbox"/> None <input type="checkbox"/> Condoms <input type="checkbox"/> Other: _____	
Social Determinants of Health (SDOH)	<input type="checkbox"/> WNL – Stable relationships w/ social/emotional support <input type="checkbox"/> Changes in family since last visit (move, job, death) <input type="checkbox"/> Problems with housing, food, employment, incarceration <input type="checkbox"/> Family stressors (mental illness, drugs, violence/abuse)	
Current Alcohol / Substance Use	<input type="checkbox"/> None <input type="checkbox"/> Alcohol	
□ Drugs (specify):	<input type="checkbox"/> IV Drugs-Current <input type="checkbox"/> Other: <input type="checkbox"/> IV Drugs-Past Hx	
Family History	<input type="checkbox"/> None <input type="checkbox"/> Diabetes	
□ Heart disease / HTN	<input type="checkbox"/> Lives/lived with someone HBV+ <input type="checkbox"/> Asthma	
□ High cholesterol	<input type="checkbox"/> Cancer <input type="checkbox"/> Other: _____	

Name:	DOB:	MR#:
Immunization History / Date	<input type="checkbox"/> None	<input type="checkbox"/> See CAIR
<input type="checkbox"/> COVID #1: <input type="checkbox"/> COVID #2: <input type="checkbox"/> COVID Booster(s):	<input type="checkbox"/> Influenza: <input type="checkbox"/> MMR: <input type="checkbox"/> Pneumococcal:	<input type="checkbox"/> Tdap: <input type="checkbox"/> Varicella: <input type="checkbox"/> Other:
USPSTF Risk Screener	Screening Tools Used	Low Risk
Adverse Childhood Experiences (screen at least once in adulthood at earliest opportunity)	<input type="checkbox"/> ACEs	<input type="checkbox"/>
Alcohol Misuse	<input type="checkbox"/> SHA , <input type="checkbox"/> CRAFFT , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>
Depression Score: _____	<input type="checkbox"/> PHQ2 , <input type="checkbox"/> PHQ9 , <input type="checkbox"/> Other:	<input type="checkbox"/>
Diabetes	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>
Drug Misuse	<input type="checkbox"/> SHA , <input type="checkbox"/> CRAFFT , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>
Dyslipidemia	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>
Hep B (Test all 18 yrs and older at least once at earliest opportunity)	<input type="checkbox"/> CDC HEP Risk , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>
Hep C (Test all 18-79 yrs old at least once at earliest opportunity)	<input type="checkbox"/> CDC HEP Risk , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>
HIV (Test all 15-65 yrs old at least once at earliest opportunity)	<input type="checkbox"/> SHA , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>
Obesity	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>
Sexually Transmitted Infections	<input type="checkbox"/> SHA , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>
SDOH	<input type="checkbox"/> SDOH , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>
Tobacco Use	<input type="checkbox"/> SHA , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>
Tuberculosis Exposure	<input type="checkbox"/> TB Risk Assessment , <input type="checkbox"/> Other:	<input type="checkbox"/>
Physical Examination		WNL
General appearance	Well-nourished & developed No abuse/neglect evident	<input type="checkbox"/>
Head	No lesions	<input type="checkbox"/>
Eyes	PERRLA, conjunctivae & sclerae clear Vision grossly normal	<input type="checkbox"/>
Ears	Canals clear, TMs normal Hearing grossly normal	<input type="checkbox"/>
Nose	Passages clear, MM pink, no lesions	<input type="checkbox"/>
Teeth	No visible cavities, grossly normal	<input type="checkbox"/>
Mouth / Pharynx	Oral mucosa pink, no lesions	<input type="checkbox"/>
Neck	Supple, no masses, thyroid not enlarged	<input type="checkbox"/>
Chest	Symmetrical, no masses	<input type="checkbox"/>
Heart	No organic murmurs, regular rhythm	<input type="checkbox"/>
Lungs	Clear to auscultation bilaterally	<input type="checkbox"/>
Abdomen	Soft, no masses, liver & spleen normal	<input type="checkbox"/>
Genitalia	Grossly normal	<input type="checkbox"/>
Male	Circ / uncircumcised, testes in scrotum Prostate Exam / Rectal	<input type="checkbox"/>

Comprehensive Health Assessment

Femoral pulses	Normal	<input type="checkbox"/>
Extremities	No deformities, full ROM	<input type="checkbox"/>
Lymph nodes	Not enlarged	<input type="checkbox"/>
Back	No scoliosis	<input type="checkbox"/>
Skin	Clear, no significant lesions	<input type="checkbox"/>
Neurologic	Alert, no gross sensory or motor deficit	<input type="checkbox"/>
Subjective / Objective		
Assessment		
Plan		
Referrals		
<input type="checkbox"/> Dentist	<input type="checkbox"/> Optometrist / Ophthalmologist	<input type="checkbox"/> Dietician / Nutritionist
<input type="checkbox"/> Drug / ETOH Tx rehab	<input type="checkbox"/> Behavioral health	<input type="checkbox"/> Tobacco cessation class
<input type="checkbox"/> Other:		
Orders		
<input type="checkbox"/> COVID 19 vaccine / booster	<input type="checkbox"/> Tdap	<input type="checkbox"/> CBC / Basic metabolic panel
<input type="checkbox"/> Hep B vaccine (if not up to date)	<input type="checkbox"/> Varicella (if not up to date)	<input type="checkbox"/> Hct / Hgb <input type="checkbox"/> Lipid panel
<input type="checkbox"/> HPV vaccine (if not up to date)	<input type="checkbox"/> Hep B Panel (if high risk)	<input type="checkbox"/> Low to moderate dose statin
<input type="checkbox"/> Influenza vaccine	<input type="checkbox"/> Hep C Antibody test (if high risk)	<input type="checkbox"/> PPD skin test <input type="checkbox"/> QFT
<input type="checkbox"/> Meningococcal vaccine (if not up to date)	<input type="checkbox"/> Chlamydia <input type="checkbox"/> Gonorrhea	<input type="checkbox"/> CXR <input type="checkbox"/> Urinalysis
<input type="checkbox"/> MMR (if not up to date)	<input type="checkbox"/> HIV (if high risk) <input type="checkbox"/> Herpes	<input type="checkbox"/> ECG <input type="checkbox"/> COVID 19 test
<input type="checkbox"/> Pneumococcal (if high risk)	<input type="checkbox"/> Syphilis <input type="checkbox"/> Trichomonas	<input type="checkbox"/> Fasting plasma glucose <input type="checkbox"/> HbA1C
<input type="checkbox"/> Other:		

Name: _____ DOB: _____ MR#: _____

Anticipatory Guidance (AG) / Education (✓ if discussed)		
Diet, Nutrition & Exercise		
<input type="checkbox"/> Weight control / obesity	<input type="checkbox"/> Vegetables, fruits	<input type="checkbox"/> Lean protein
<input type="checkbox"/> Whole grains / iron-rich foods	<input type="checkbox"/> Limit fatty, sugary & salty foods	<input type="checkbox"/> Limit candy, chips & ice cream
<input type="checkbox"/> Physical activity / exercise	<input type="checkbox"/> Healthy food choices	<input type="checkbox"/> Eating disorder
Accident Prevention & Guidance		
<input type="checkbox"/> Alcohol/drug/substance misuse counseling	<input type="checkbox"/> Avoid risk-taking behavior	<input type="checkbox"/> Independence
<input type="checkbox"/> Signs of depression (suicidal ideation)	<input type="checkbox"/> Gun safety	<input type="checkbox"/> Personal development
<input type="checkbox"/> Mental health (emotional support)	<input type="checkbox"/> Violent behavior	<input type="checkbox"/> Goals in life
<input type="checkbox"/> Diabetes Management	<input type="checkbox"/> Motor vehicle safety (DUI / no texting & driving)	<input type="checkbox"/> Academic or work plans
<input type="checkbox"/> Safe sex practices (condoms, contraception, HIV/AIDS)	<input type="checkbox"/> Seat belt	<input type="checkbox"/> Family support, social interaction & communication
<input type="checkbox"/> Skin cancer prevention	<input type="checkbox"/> Safety helmet	<input type="checkbox"/> Testicular self-exam
<input type="checkbox"/> Smoking/vaping use/exposure	<input type="checkbox"/> Routine dental care	<input type="checkbox"/> Sex education (partner selection)
Tobacco Use / Cessation		
<input type="checkbox"/> Never smoked or used tobacco products		
<input type="checkbox"/> Former smoker: # Yrs smoked ____ # Cigarettes smoked/day ____ Quit date ____		
<input type="checkbox"/> Current smoker: # Yrs smoked ____ # Cigarettes smoked/day ____		
Type used: <input type="checkbox"/> Cigarettes <input type="checkbox"/> Chewing tobacco <input type="checkbox"/> Vaping products <input type="checkbox"/> Other:		
<input type="checkbox"/> Advised to quit smoking	<input type="checkbox"/> Discussed smoking cessation medication	<input type="checkbox"/> Discussed smoking cessation strategies
Next Appointment		
<input type="checkbox"/> 1 year	<input type="checkbox"/> RTC PRN	<input type="checkbox"/> Other:

Documentation Reminders		
<input type="checkbox"/> Screening tools (TB, Depression, HEP B, etc.) are completed, dated, & reviewed by provider	<input type="checkbox"/> Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)	<input type="checkbox"/> Problem/Medication Lists updated

MA / Nurse Signature	Title	Date
Provider Signature	Title	Date

Notes (include date, time, signature, and title on all entries)
<input type="checkbox"/> Member refused the following screening/orders:

Comprehensive Health Assessment

40 to 49 Years: Female at Birth	Actual Age: _____	Date: _____
Primary Language	_____	
Interpreter Requested	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused Name of Interpreter: _____	
Intake	Vital Signs	
Allergies / Reaction	Temp	_____
Height	BP	_____
Weight <input type="checkbox"/> Significant loss/gain: _____ lbs	Pulse	_____
BMI Value	Resp	_____
Pain	Location: _____ Scale: 0 1 2 3 4 5 6 7 8 9 10	
Cultural Needs (e.g., cultural background/traditions, religious practices, dietary preference/restrictions, and healthcare beliefs): <input type="checkbox"/> Unremarkable		
Country of Birth: <input type="checkbox"/> US <input type="checkbox"/> Other: _____ At least 1 parent born in Africa, Asia, Pacific Islands: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Dental Home	Dental visit within past 12 months: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Advance Directive Info Given/Discussed	<input type="checkbox"/> Yes <input type="checkbox"/> Refused	
Chronic Problems/Significant Conditions: <input type="checkbox"/> None <input type="checkbox"/> See Problem List <input type="checkbox"/> Asthma <input type="checkbox"/> Cancer <input type="checkbox"/> Depression <input type="checkbox"/> DM <input type="checkbox"/> Dialysis <input type="checkbox"/> Heart Disease <input type="checkbox"/> HEP B <input type="checkbox"/> HEP C <input type="checkbox"/> High Cholesterol <input type="checkbox"/> HIV <input type="checkbox"/> HTN <input type="checkbox"/> Liver Disease <input type="checkbox"/> Seizures <input type="checkbox"/> STI <input type="checkbox"/> Uses DME <input type="checkbox"/> ≥ 2 ER visits in 12 months <input type="checkbox"/> Other: _____		
Functional Limitations (check all that apply): <input type="checkbox"/> Unremarkable <input type="checkbox"/> Seeing <input type="checkbox"/> Hearing <input type="checkbox"/> Mobility <input type="checkbox"/> Communication <input type="checkbox"/> Cognition <input type="checkbox"/> Self-care		
Current Medications/Vitamins: <input type="checkbox"/> See Medication List <input type="checkbox"/> taking 0.4 to 0.8 mg of folic acid daily (for reproductive females)		
Education (last grade completed): _____ Health education preference: <input type="checkbox"/> Verbal <input type="checkbox"/> Visual <input type="checkbox"/> Multimedia <input type="checkbox"/> Other: _____		
Interval History		
Diet / Nutrition	<input type="checkbox"/> Regular <input type="checkbox"/> Low calorie <input type="checkbox"/> ADA <input type="checkbox"/> Iron-rich foods <input type="checkbox"/> Other: _____	
Appetite	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
Physical Activity	<input type="checkbox"/> Inactive (little or none) <input type="checkbox"/> Some (< 2 ½ hrs/week) <input type="checkbox"/> Active (≥ 2 ½ hrs per week w/ 2 days strength training)	
LMP:	G P A	<input type="checkbox"/> Menorrhagia <input type="checkbox"/> Menopause
Hysterectomy	<input type="checkbox"/> Partial <input type="checkbox"/> Total	
Sexually active	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Multiple Partners	
Contraceptive Used	<input type="checkbox"/> None <input type="checkbox"/> Condoms <input type="checkbox"/> Other: _____	
Intimate Partner Violence / SDOH In the last 12 months	Has anyone physically hurt you? <input type="checkbox"/> Yes <input type="checkbox"/> No Has anyone insulted or humiliated you? <input type="checkbox"/> Yes <input type="checkbox"/> No Has anyone threatened you? <input type="checkbox"/> Yes <input type="checkbox"/> No Has anyone screamed or cursed at you? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Last PAP/HPV	Date: _____	<input type="checkbox"/> WNL
Last Mammogram	Date: _____	<input type="checkbox"/> WNL
Last Colonoscopy	Date: _____	<input type="checkbox"/> WNL

Name: _____ DOB: _____ MR#: _____

Current Alcohol / Substance Use	<input type="checkbox"/> None	<input type="checkbox"/> Alcohol	
<input type="checkbox"/> Drugs (specify): _____	<input type="checkbox"/> IV Drugs-Current <input type="checkbox"/> IV Drugs-Past Hx	<input type="checkbox"/> Other: _____	
Family History	<input type="checkbox"/> None	<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Heart disease / HTN	<input type="checkbox"/> Lives/lived with someone HBV+	<input type="checkbox"/> Hip fracture	
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Cancer	<input type="checkbox"/> Other: _____	
Immunization History / Date	<input type="checkbox"/> None	<input type="checkbox"/> See CAIR	
<input type="checkbox"/> COVID #1: <input type="checkbox"/> COVID #2: <input type="checkbox"/> COVID Booster(s):	<input type="checkbox"/> Influenza: <input type="checkbox"/> MMR:	<input type="checkbox"/> Tdap: <input type="checkbox"/> Varicella: <input type="checkbox"/> Exempt (DOB < 1980 & non-healthcare worker)	
<input type="checkbox"/> Hepatitis B:	<input type="checkbox"/> Pneumococcal:	<input type="checkbox"/> Other: _____	
USPSTF Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/Orders/AG)
Adverse Childhood Experiences (screen at least once in adulthood at earliest opportunity)	<input type="checkbox"/> ACES	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol Misuse	<input type="checkbox"/> SHA , <input type="checkbox"/> CRAFFT , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Cervical Cancer	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Colorectal Cancer	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Depression Score: _____	<input type="checkbox"/> PHQ2 , <input type="checkbox"/> PHQ9 , <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Drug Misuse	<input type="checkbox"/> SHA , <input type="checkbox"/> CRAFFT , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Dyslipidemia	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Hep B (Test all 18 yrs and older at least once at earliest opportunity)	<input type="checkbox"/> CDC HEP Risk , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Hep C (Test all 18-79 yrs old at least once at earliest opportunity)	<input type="checkbox"/> CDC HEP Risk , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
HIV (Test all 15-65 yrs old at least once at earliest opportunity)	<input type="checkbox"/> SHA , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Obesity	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Sexually Transmitted Infections	<input type="checkbox"/> SHA , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
SDOH / Intimate Partner Violence	<input type="checkbox"/> SDOH , <input type="checkbox"/> HITS , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco Use	<input type="checkbox"/> SHA , <input type="checkbox"/> CRAFFT , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis Exposure	<input type="checkbox"/> TB Risk Screener , <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Physical Examination		WNL	
General appearance	Well-nourished & developed No abuse/neglect evident	<input type="checkbox"/>	
Head	No lesions	<input type="checkbox"/>	
Eyes	PERRLA, conjunctivae & sclerae clear Vision grossly normal	<input type="checkbox"/>	
Ears	Canals clear, TMs normal Hearing grossly normal	<input type="checkbox"/>	

Comprehensive Health Assessment

Nose	Passages clear, MM pink, no lesions	<input type="checkbox"/>
Teeth	No visible cavities, grossly normal	<input type="checkbox"/>
Mouth / Pharynx	Oral mucosa pink, no lesions	<input type="checkbox"/>
Neck	Supple, no masses, thyroid not enlarged	<input type="checkbox"/>
Chest / Breast	Symmetrical, no masses	<input type="checkbox"/>
Heart	No organic murmurs, regular rhythm	<input type="checkbox"/>
Lungs	Clear to auscultation bilaterally	<input type="checkbox"/>
Abdomen	Soft, no masses, liver & spleen normal	<input type="checkbox"/>
Genitalia	Grossly normal	<input type="checkbox"/>
Female	No lesions, normal external appearance	<input type="checkbox"/>
Vaginal exam	Done or completed elsewhere OB/GYN name:	<input type="checkbox"/>
Femoral pulses	Present & equal	<input type="checkbox"/>
Extremities	No deformities, full ROM	<input type="checkbox"/>
Lymph nodes	Not enlarged	<input type="checkbox"/>
Back	No scoliosis	<input type="checkbox"/>
Skin	Clear, no significant lesions	<input type="checkbox"/>
Neurologic	Alert, no gross sensory or motor deficit	<input type="checkbox"/>
Subjective / Objective		
Assessment		
Plan		
Referrals		
<input type="checkbox"/> Dentist	<input type="checkbox"/> Optometrist / Ophthalmologist	<input type="checkbox"/> Dietician / Nutritionist
<input type="checkbox"/> Drug / ETOH Tx rehab	<input type="checkbox"/> Behavioral health	<input type="checkbox"/> Tobacco cessation class
<input type="checkbox"/> OB/GYN	<input type="checkbox"/> Other:	
Orders		
<input type="checkbox"/> COVID 19 vaccine / booster	<input type="checkbox"/> Hep B Panel (if high risk)	<input type="checkbox"/> CBC / Basic metabolic panel
<input type="checkbox"/> Hep B vaccine (if not up to date)	<input type="checkbox"/> Hep C Antibody test (if high risk)	<input type="checkbox"/> Hct / Hgb <input type="checkbox"/> Lipid panel
<input type="checkbox"/> Influenza vaccine	<input type="checkbox"/> Chlamydia <input type="checkbox"/> Gonorrhea	<input type="checkbox"/> PPD skin test <input type="checkbox"/> QFT
<input type="checkbox"/> MMR (if not up to date)	<input type="checkbox"/> HIV (if high risk) <input type="checkbox"/> Herpes	<input type="checkbox"/> CXR <input type="checkbox"/> Urinalysis
<input type="checkbox"/> Pneumococcal (if high risk)	<input type="checkbox"/> Syphilis <input type="checkbox"/> Trichomonas	<input type="checkbox"/> ECG <input type="checkbox"/> COVID 19 test
<input type="checkbox"/> Tdap	<input type="checkbox"/> Rx for folic acid 0.4-0.8mg daily	<input type="checkbox"/> Fasting plasma glucose <input type="checkbox"/> Oral glucose tolerance
<input type="checkbox"/> Varicella (if not up to date)	<input type="checkbox"/> gFOBT or Fit <input type="checkbox"/> Colonoscopy	<input type="checkbox"/> HbA1C <input type="checkbox"/> Low to moderate dose statin
<input type="checkbox"/> Zoster (if high risk)	<input type="checkbox"/> PAP <input type="checkbox"/> HPV	<input type="checkbox"/> Bone Density Test <input type="checkbox"/> Mammogram
<input type="checkbox"/> Other:		

Name: _____ DOB: _____ MR#: _____

Anticipatory Guidance (AG) / Education (✓ if discussed)		
Diet, Nutrition & Exercise		
<input type="checkbox"/> Weight control / obesity	<input type="checkbox"/> Vegetables, fruits	<input type="checkbox"/> Lean protein
<input type="checkbox"/> Whole grains / iron-rich foods	<input type="checkbox"/> Limit fatty, sugary & salty foods	<input type="checkbox"/> Limit candy, chips & ice cream
<input type="checkbox"/> Physical activity / exercise	<input type="checkbox"/> Healthy food choices	<input type="checkbox"/> Eating disorder
Accident Prevention & Guidance		
<input type="checkbox"/> Alcohol/drug/substance misuse counseling	<input type="checkbox"/> Avoid risk-taking behavior	<input type="checkbox"/> Independence
<input type="checkbox"/> Signs of depression (suicidal ideation)	<input type="checkbox"/> Skin cancer prevention	<input type="checkbox"/> Personal development
<input type="checkbox"/> Mental health (emotional support)	<input type="checkbox"/> Violent behavior	<input type="checkbox"/> Goals in life
<input type="checkbox"/> Diabetes management	<input type="checkbox"/> Mindful of daily movements	<input type="checkbox"/> Work activities
<input type="checkbox"/> Intimate partner violence	<input type="checkbox"/> Motor vehicle safety (DUI / no texting & driving)	<input type="checkbox"/> Family support, social interaction & communication
<input type="checkbox"/> Sex education (partner selection)	<input type="checkbox"/> Seat belt	<input type="checkbox"/> Self-breast exam
<input type="checkbox"/> Safe sex practices (condoms, contraception, HIV/AIDS)	<input type="checkbox"/> Safety helmet	<input type="checkbox"/> Aging process
<input type="checkbox"/> Smoking/vaping use/exposure	<input type="checkbox"/> Routine dental care	<input type="checkbox"/> Perimenopause education
Tobacco Use / Cessation		
<input type="checkbox"/> Never smoked or used tobacco products		
<input type="checkbox"/> Former smoker: # Yrs smoked ____ # Cigarettes smoked/day ____ Quit date ____		
<input type="checkbox"/> Current smoker: # Yrs smoked ____ # Cigarettes smoked/day ____		
Type used: <input type="checkbox"/> Cigarettes <input type="checkbox"/> Chewing tobacco <input type="checkbox"/> Vaping products <input type="checkbox"/> Other:		
<input type="checkbox"/> Advised to quit smoking	<input type="checkbox"/> Discussed smoking cessation medication	<input type="checkbox"/> Discussed smoking cessation strategies
Next Appointment		
<input type="checkbox"/> 1 year	<input type="checkbox"/> RTC PRN	<input type="checkbox"/> Other:

Documentation Reminders		
<input type="checkbox"/> Screening tools (TB, Depression, HEP B, etc.) are completed, dated, & reviewed by provider	<input type="checkbox"/> Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)	<input type="checkbox"/> Problem / Medication Lists updated

MA / Nurse Signature	Title	Date
Provider Signature	Title	Date

Notes (include date, time, signature, and title on all entries)
<input type="checkbox"/> Member refused the following screening/orders:

Comprehensive Health Assessment

40 to 49 Years: Male at Birth	Actual Age: _____	Date: _____
Primary Language		
Interpreter Requested	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused Name of Interpreter: _____	
Intake	Vital Signs	
Allergies / Reaction	Temp	
Height	BP	
Weight <input type="checkbox"/> Significant loss/gain: _____ lbs	Pulse	
BMI Value	Resp	
Pain	Location: _____ Scale: 0 1 2 3 4 5 6 7 8 9 10	
Cultural Needs (e.g., cultural background/traditions, religious practices, dietary preference/restrictions, and healthcare beliefs): <input type="checkbox"/> Unremarkable		
Country of Birth: <input type="checkbox"/> US <input type="checkbox"/> Other: _____ At least 1 parent born in Africa, Asia, Pacific Islands: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Dental Home	Dental visit within past 12 months: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Advance Directive Info Given/Discussed	<input type="checkbox"/> Yes <input type="checkbox"/> Refused	
Chronic Problems/Significant Conditions: <input type="checkbox"/> None <input type="checkbox"/> See Problem List <input type="checkbox"/> Asthma <input type="checkbox"/> Cancer <input type="checkbox"/> Depression <input type="checkbox"/> DM <input type="checkbox"/> Dialysis <input type="checkbox"/> Heart Disease <input type="checkbox"/> HEP B <input type="checkbox"/> HEP C <input type="checkbox"/> High Cholesterol <input type="checkbox"/> HIV <input type="checkbox"/> HTN <input type="checkbox"/> Liver Disease <input type="checkbox"/> Seizures <input type="checkbox"/> STI <input type="checkbox"/> Uses DME <input type="checkbox"/> ≥ 2 ER visits in 12 months <input type="checkbox"/> Other: _____		
Functional Limitations (check all that apply): <input type="checkbox"/> Unremarkable <input type="checkbox"/> Seeing <input type="checkbox"/> Hearing <input type="checkbox"/> Mobility <input type="checkbox"/> Communication <input type="checkbox"/> Cognition <input type="checkbox"/> Self-care		
Current Medications/Vitamins: <input type="checkbox"/> See Medication List		
Education (last grade completed): _____ Health education preference: <input type="checkbox"/> Verbal <input type="checkbox"/> Visual <input type="checkbox"/> Multimedia <input type="checkbox"/> Other: _____		
Interval History		
Diet / Nutrition	<input type="checkbox"/> Regular <input type="checkbox"/> Low calorie <input type="checkbox"/> ADA <input type="checkbox"/> Iron-rich foods <input type="checkbox"/> Other: _____	
Appetite	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
Physical Activity	<input type="checkbox"/> Inactive (little or none) <input type="checkbox"/> Some (< 2 ½ hrs/week) <input type="checkbox"/> Active (≥ 2 ½ hrs per week w/ 2 days strength training)	
Sexually active	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Multiple Partners <input type="checkbox"/> MSM	
Contraceptive Used	<input type="checkbox"/> None <input type="checkbox"/> Condoms <input type="checkbox"/> Other: _____	
Last Colonoscopy	Date: _____	<input type="checkbox"/> WNL
Social Determinants of Health (SDOH)	<input type="checkbox"/> WNL-Stable relationships w/ social/emotional support <input type="checkbox"/> Changes in family since last visit (move, job, death) <input type="checkbox"/> Problems with housing/food/employment/incarceration <input type="checkbox"/> Family stressors(mental illness, drugs, violence/abuse)	
Current Alcohol / Substance Use	<input type="checkbox"/> None	<input type="checkbox"/> Alcohol
<input type="checkbox"/> Drugs (specify): _____	<input type="checkbox"/> IV Drugs-Current <input type="checkbox"/> IV Drugs-Past Hx	<input type="checkbox"/> Other: _____
Family History	<input type="checkbox"/> Unremarkable	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Heart disease / HTN	<input type="checkbox"/> Lives/lived with someone HBV+	<input type="checkbox"/> Asthma
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Cancer	<input type="checkbox"/> Other: _____

Name:	DOB:	MR#:	
Immunization History / Date	<input type="checkbox"/> None	<input type="checkbox"/> See CAIR	
<input type="checkbox"/> COVID #1:	<input type="checkbox"/> Influenza:	<input type="checkbox"/> Tdap:	
<input type="checkbox"/> COVID #2:	<input type="checkbox"/> MMR:	<input type="checkbox"/> Varicella: <input type="checkbox"/> Exempt (DOB < 1980 & non-healthcare worker)	
<input type="checkbox"/> COVID Booster(s):	<input type="checkbox"/> Pneumococcal:	<input type="checkbox"/> Other:	
<input type="checkbox"/> Hepatitis B:	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/> ACEs	
USPSTF Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/Orders/AG)
Adverse Childhood Experiences (screen at least once in adulthood at earliest opportunity)	<input type="checkbox"/> SHA , <input type="checkbox"/> CRAFFT , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol Misuse	<input type="checkbox"/> PHQ2 , <input type="checkbox"/> PHQ9 , <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Colorectal Cancer	<input type="checkbox"/> SHA , <input type="checkbox"/> CRAFFT , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Depression Score: _____	<input type="checkbox"/> SDOH , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/> TB Risk Assessment , <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Drug Misuse	<input type="checkbox"/> SHA , <input type="checkbox"/> CRAFFT , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Dyslipidemia	<input type="checkbox"/> SHA , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Hep B (Test all 18 yrs and older at least once at earliest opportunity)	<input type="checkbox"/> CDC HEP Risk , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Hep C (Test all 18-79 yrs old at least once at earliest opportunity)	<input type="checkbox"/> SHA , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
HIV (Test all 15-65 yrs old at least once at earliest opportunity)	<input type="checkbox"/> SHA , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Obesity	<input type="checkbox"/> SHA , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Sexually Transmitted Infections	<input type="checkbox"/> SDOH , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
SDOH	<input type="checkbox"/> SHA , <input type="checkbox"/> CRAFFT , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco Use	<input type="checkbox"/> TB Risk Assessment , <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis Exposure	Physical Examination WNL		
General appearance	Well-nourished & developed No abuse/neglect evident	<input type="checkbox"/>	
Head	No lesions	<input type="checkbox"/>	
Eyes	PERRLA, conjunctivae & sclerae clear Vision grossly normal	<input type="checkbox"/>	
Ears	Canals clear, TMs normal Hearing grossly normal	<input type="checkbox"/>	
Nose	Passages clear, MM pink, no lesions	<input type="checkbox"/>	
Teeth	No visible cavities, grossly normal	<input type="checkbox"/>	
Mouth / Pharynx	Oral mucosa pink, no lesions	<input type="checkbox"/>	
Neck	Supple, no masses, thyroid not enlarged	<input type="checkbox"/>	
Chest	Symmetrical, no masses	<input type="checkbox"/>	
Heart	No organic murmurs, regular rhythm	<input type="checkbox"/>	
Lungs	Clear to auscultation bilaterally	<input type="checkbox"/>	
Abdomen	Soft, no masses, liver & spleen normal	<input type="checkbox"/>	

Comprehensive Health Assessment

Genitalia	Grossly normal	<input type="checkbox"/>
Male	Circ/uncircumcised, testes in scrotum Prostate Exam / Rectal	<input type="checkbox"/>
Femoral pulses	Present & equal	<input type="checkbox"/>
Extremities	No deformities, full ROM	<input type="checkbox"/>
Lymph nodes	Not enlarged	<input type="checkbox"/>
Back	No scoliosis	<input type="checkbox"/>
Skin	Clear, no significant lesions	<input type="checkbox"/>
Neurologic	Alert, no gross sensory or motor deficit	<input type="checkbox"/>

Subjective / Objective

Assessment

Plan

Referrals

<input type="checkbox"/> Dentist	<input type="checkbox"/> Optometrist / Ophthalmologist	<input type="checkbox"/> Dietician / Nutritionist
<input type="checkbox"/> Drug / ETOH Tx rehab	<input type="checkbox"/> Behavioral health	<input type="checkbox"/> Tobacco cessation class
<input type="checkbox"/> Other:		

Orders

<input type="checkbox"/> COVID 19 vaccine / booster	<input type="checkbox"/> Hep B Panel (if high risk)	<input type="checkbox"/> CBC / Basic metabolic panel
<input type="checkbox"/> Hep B vaccine (if not up to date)	<input type="checkbox"/> Hep C Antibody test (if high risk)	<input type="checkbox"/> Hct / Hgb
<input type="checkbox"/> Influenza vaccine	<input type="checkbox"/> Chlamydia	<input type="checkbox"/> Lipid panel
<input type="checkbox"/> MMR (if not up to date)	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Low to moderate dose statin
<input type="checkbox"/> Pneumococcal vaccine	<input type="checkbox"/> HIV	<input type="checkbox"/> PPD skin test
<input type="checkbox"/> Tdap	<input type="checkbox"/> Herpes	<input type="checkbox"/> QFT
<input type="checkbox"/> Varicella (if not up to date)	<input type="checkbox"/> Syphilis	<input type="checkbox"/> CXR
<input type="checkbox"/> Zoster	<input type="checkbox"/> Trichomonas	<input type="checkbox"/> Urinalysis
<input type="checkbox"/> Other:	<input type="checkbox"/> gFOBT or Fit	<input type="checkbox"/> ECG
	<input type="checkbox"/> PSA	<input type="checkbox"/> COVID 19 test
	<input type="checkbox"/> HbA1C	<input type="checkbox"/> Fasting plasma glucose
	<input type="checkbox"/> Oral glucose tolerance test	

Name: _____ DOB: _____ MR#: _____

Anticipatory Guidance (AG) / Education (✓ if discussed)

Diet, Nutrition & Exercise

<input type="checkbox"/> Weight control / obesity	<input type="checkbox"/> Vegetables, fruits	<input type="checkbox"/> Lean protein
<input type="checkbox"/> Whole grains / iron-rich foods	<input type="checkbox"/> Limit fatty, sugary & salty foods	<input type="checkbox"/> Limit candy, chips & ice cream
<input type="checkbox"/> Physical activity / exercise	<input type="checkbox"/> Healthy food choices	<input type="checkbox"/> Eating disorder

Accident Prevention & Guidance

<input type="checkbox"/> Alcohol/drug/substance misuse counseling	<input type="checkbox"/> Avoid risk-taking behavior	<input type="checkbox"/> Independence
<input type="checkbox"/> Signs of depression (suicidal ideation)	<input type="checkbox"/> Gun safety	<input type="checkbox"/> Personal development
<input type="checkbox"/> Mental health (emotional support)	<input type="checkbox"/> Violent behavior	<input type="checkbox"/> Goals in life
<input type="checkbox"/> Diabetes management	<input type="checkbox"/> Mindful of daily movements	<input type="checkbox"/> Work activities
<input type="checkbox"/> Sex education (partner selection)	<input type="checkbox"/> Motor vehicle safety (DUI / no texting & driving)	<input type="checkbox"/> Family support, social interaction & communication
<input type="checkbox"/> Safe sex practices (condoms, contraception, HIV/AIDS)	<input type="checkbox"/> Seat belt	<input type="checkbox"/> Testicular self-exam
<input type="checkbox"/> Smoking/vaping use/exposure	<input type="checkbox"/> Skin cancer Prevention	<input type="checkbox"/> Routine dental care

Tobacco Use / Cessation

Never smoked or used tobacco products

Former smoker: # Yrs smoked ____ # Cigarettes smoked/day ____ Quit date ____

Current smoker: # Yrs smoked ____ # Cigarettes smoked/day ____

Type used: Cigarettes Chewing tobacco Vaping products Other:

<input type="checkbox"/> Advised to quit smoking	<input type="checkbox"/> Discussed smoking cessation medication	<input type="checkbox"/> Discussed smoking cessation strategies
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Next Appointment

<input type="checkbox"/> 1 year	<input type="checkbox"/> RTC PRN	<input type="checkbox"/> Other:
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Documentation Reminders

<input type="checkbox"/> Screening tools (TB, Depression, HEP B, etc.) are completed, dated, & reviewed by provider	<input type="checkbox"/> Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)	<input type="checkbox"/> Problem / Medication Lists updated
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MA / Nurse Signature	Title	Date
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Provider Signature	Title	Date
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Notes (include date, time, signature, and title on all entries)

Member refused the following screening/orders:

Comprehensive Health Assessment

50+ Years: Female at Birth	Actual Age: _____	Date: _____
Primary Language		
Interpreter Requested	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused Name of Interpreter: _____	
Intake		Vital Signs
Allergies / Reaction		Temp _____
Height		BP _____
Weight <input type="checkbox"/> Significant loss/gain: _____ lbs		Pulse _____
BMI Value		Resp _____
Pain	Location: _____ Scale: 0 1 2 3 4 5 6 7 8 9 10	
Cultural Needs (e.g., cultural background/traditions, religious practices, dietary preference/restrictions, and healthcare beliefs): <input type="checkbox"/> Unremarkable		
Country of Birth: <input type="checkbox"/> US <input type="checkbox"/> Other: _____ At least 1 parent born in Africa, Asia, Pacific Islands: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Dental Home	Dental visit within past 12 months: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Advance Directive Info Given/Discussed	<input type="checkbox"/> Yes <input type="checkbox"/> Refused	
Chronic Problems/Significant Conditions: <input type="checkbox"/> None <input type="checkbox"/> See Problem List <input type="checkbox"/> Asthma <input type="checkbox"/> Cancer <input type="checkbox"/> Depression <input type="checkbox"/> DM <input type="checkbox"/> Dialysis <input type="checkbox"/> Heart Disease <input type="checkbox"/> HEP B <input type="checkbox"/> HEP C <input type="checkbox"/> High Cholesterol <input type="checkbox"/> HIV <input type="checkbox"/> HTN <input type="checkbox"/> Liver Disease <input type="checkbox"/> Seizures <input type="checkbox"/> STI <input type="checkbox"/> Uses DME <input type="checkbox"/> ≥ 2 ER visits in 12 months <input type="checkbox"/> Other: _____		
Functional Limitations (check all that apply): <input type="checkbox"/> Unremarkable <input type="checkbox"/> Seeing <input type="checkbox"/> Hearing <input type="checkbox"/> Mobility <input type="checkbox"/> Communication <input type="checkbox"/> Cognition <input type="checkbox"/> Self-care		
Current Medications/Vitamins: <input type="checkbox"/> See Medication List		
Education (last grade completed): _____ Health education preference: <input type="checkbox"/> Verbal <input type="checkbox"/> Visual <input type="checkbox"/> Multimedia <input type="checkbox"/> Other: _____		
Interval History		
Diet / Nutrition	<input type="checkbox"/> Regular <input type="checkbox"/> Low calorie <input type="checkbox"/> ADA <input type="checkbox"/> Iron-rich foods <input type="checkbox"/> Other: _____	
Appetite	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
Physical Activity	<input type="checkbox"/> Inactive (little or none) <input type="checkbox"/> Some (< 2 ½ hrs/week) <input type="checkbox"/> Active (≥ 2 ½ hrs per week w/ 2 days strength training)	
LMP:	G P A	<input type="checkbox"/> Menorrhagia <input type="checkbox"/> Menopause
Hysterectomy	<input type="checkbox"/> Partial <input type="checkbox"/> Total	
Sexually active	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Multiple Partners	
Contraceptive Used	<input type="checkbox"/> None <input type="checkbox"/> Condoms <input type="checkbox"/> Other: _____	
Last PAP/HPV	Date: _____	<input type="checkbox"/> WNL
Last Mammogram	Date: _____	<input type="checkbox"/> WNL
Last Colonoscopy	Date: _____	<input type="checkbox"/> WNL
Social Determinants of Health (SDOH)	<input type="checkbox"/> WNL-Stable relationships w/ social/emotional support <input type="checkbox"/> Changes in family since last visit (move, job, death) <input type="checkbox"/> Problems with housing, food, employment <input type="checkbox"/> Family stressors (mental illness, drugs, violence/abuse)	

Name:	DOB:	MR#:	
Current Alcohol / Substance Use	<input type="checkbox"/> None	<input type="checkbox"/> Alcohol	
<input type="checkbox"/> Drugs (specify): _____	<input type="checkbox"/> IV Drugs-Current <input type="checkbox"/> IV Drugs-Past Hx	<input type="checkbox"/> Other: _____	
Family History	<input type="checkbox"/> None	<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Heart disease / HTN	<input type="checkbox"/> Lives/lived with someone HBV+	<input type="checkbox"/> Hip fracture	
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Cancer	<input type="checkbox"/> Other: _____	
Immunization History / Date	<input type="checkbox"/> None <input type="checkbox"/> See CAIR	<input type="checkbox"/> Tdap: _____	
<input type="checkbox"/> COVID #1: <input type="checkbox"/> COVID #2:	<input type="checkbox"/> Influenza: <input type="checkbox"/> COVID Booster(s):	<input type="checkbox"/> Zoster: <input type="checkbox"/> MMR: <input type="checkbox"/> Exempt (DOB <1957 & non-healthcare worker) <input type="checkbox"/> Varicella: <input type="checkbox"/> Exempt (non-healthcare worker)	
<input type="checkbox"/> Hepatitis B:	<input type="checkbox"/> Pneumococcal:	<input type="checkbox"/> Other: _____	
USPSTF Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/Orders/AG)
Adverse Childhood Experiences (screen at least once in adulthood at earliest opportunity)	<input type="checkbox"/> ACEs	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol Misuse	<input type="checkbox"/> SHA , <input type="checkbox"/> CRAFFT , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Cervical Cancer	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Cognitive Health (Start at 65 yrs old) Score: _____	<input type="checkbox"/> MINI-COG , <input type="checkbox"/> AD8 , <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Colorectal Cancer	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Depression Score: _____	<input type="checkbox"/> PHQ2 , <input type="checkbox"/> PHQ9 , <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Drug Misuse	<input type="checkbox"/> SHA , <input type="checkbox"/> CRAFFT , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Dyslipidemia	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Hep B (Test all 18 yrs and older at least once at earliest opportunity)	<input type="checkbox"/> CDC HEP Risk , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Hep C (Test all 18-79 yrs old at least once at earliest opportunity)	<input type="checkbox"/> CDC HEP Risk , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
HIV (Test all 15-65 yrs old at least once at earliest opportunity)	<input type="checkbox"/> SHA , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Lung Cancer	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Obesity	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Sexually Transmitted Infections	<input type="checkbox"/> SHA , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
SDOH	<input type="checkbox"/> SDOH , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco Use	<input type="checkbox"/> SHA , <input type="checkbox"/> CRAFFT , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis Exposure	<input type="checkbox"/> TB Risk Screener , <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Physical Examination	WNL		
General appearance	Well-nourished & developed No abuse/neglect evident	<input type="checkbox"/>	
Head	No lesions	<input type="checkbox"/>	

Comprehensive Health Assessment

Eyes	PERRLA, conjunctivae & sclerae clear Vision grossly normal	<input type="checkbox"/>
Ears	Canals clear, TMs normal Hearing grossly normal	<input type="checkbox"/>
Nose	Passages clear, MM pink, no lesions	<input type="checkbox"/>
Teeth	No visible cavities, grossly normal	<input type="checkbox"/>
Mouth / Pharynx	Oral mucosa pink, no lesions	<input type="checkbox"/>
Neck	Supple, no masses, thyroid not enlarged	<input type="checkbox"/>
Chest / Breast	Symmetrical, no masses	<input type="checkbox"/>
Heart	No organic murmurs, regular rhythm	<input type="checkbox"/>
Lungs	Clear to auscultation bilaterally	<input type="checkbox"/>
Abdomen	Soft, no masses, liver & spleen normal	<input type="checkbox"/>
Genitalia	Grossly normal	<input type="checkbox"/>
Female	No lesions, normal external appearance	<input type="checkbox"/>
Vaginal exam	Done or completed elsewhere OB/GYN name:	<input type="checkbox"/>
Femoral pulses	Present & equal	<input type="checkbox"/>
Extremities	No deformities, full ROM	<input type="checkbox"/>
Lymph nodes	Not enlarged	<input type="checkbox"/>
Back	No scoliosis	<input type="checkbox"/>
Skin	Clear, no significant lesions	<input type="checkbox"/>
Neurologic	Alert, no gross sensory or motor deficit	<input type="checkbox"/>
Subjective / Objective		
Assessment		
Plan		
Referrals		
<input type="checkbox"/> Dentist	<input type="checkbox"/> Optometrist / Ophthalmologist	<input type="checkbox"/> Dietician / Nutritionist
<input type="checkbox"/> Drug / ETOH Tx rehab	<input type="checkbox"/> Behavioral health	<input type="checkbox"/> Tobacco cessation class
<input type="checkbox"/> OB/GYN	<input type="checkbox"/> Other:	
Orders		
<input type="checkbox"/> COVID 19 vaccine / booster	<input type="checkbox"/> Hep C Antibody test (if high risk)	<input type="checkbox"/> CBC / Basic metabolic panel
<input type="checkbox"/> Hep B vaccine (if not up to date)	<input type="checkbox"/> Chlamydia <input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Hct / Hgb <input type="checkbox"/> Lipid panel
<input type="checkbox"/> Influenza vaccine	<input type="checkbox"/> HIV (if high risk) <input type="checkbox"/> Herpes	<input type="checkbox"/> PPD skin test <input type="checkbox"/> QFT
<input type="checkbox"/> MMR (if not up to date)	<input type="checkbox"/> Syphilis <input type="checkbox"/> Trichomonas	<input type="checkbox"/> CXR <input type="checkbox"/> Urinalysis
<input type="checkbox"/> Pneumococcal	<input type="checkbox"/> Rx for folic acid 0.4-0.8mg daily	<input type="checkbox"/> ECG <input type="checkbox"/> COVID 19 test
<input type="checkbox"/> Tdap	<input type="checkbox"/> gFOBT or Fit <input type="checkbox"/> Colonoscopy	<input type="checkbox"/> Fasting plasma glucose <input type="checkbox"/> Oral glucose tolerance test
<input type="checkbox"/> Varicella (if not up to date)	<input type="checkbox"/> PAP <input type="checkbox"/> HPV	<input type="checkbox"/> HbA1C <input type="checkbox"/> Low to moderate dose statin

Name: _____ **DOB:** _____ **MR#:** _____

<input type="checkbox"/> Zoster	<input type="checkbox"/> Mammogram	<input type="checkbox"/> Low Dose CT (20-pack year smoking history & currently smoke or have quit within past 15 years)
<input type="checkbox"/> Hep B Panel (if high risk)	<input type="checkbox"/> Bone Density Test	
<input type="checkbox"/> Other:		
Anticipatory Guidance (AG) / Education (✓ if discussed)		
Diet, Nutrition & Exercise		
<input type="checkbox"/> Weight control / obesity	<input type="checkbox"/> Vegetables, fruits	<input type="checkbox"/> Lean protein
<input type="checkbox"/> Whole grains / iron-rich foods	<input type="checkbox"/> Limit fatty, sugary & salty foods	<input type="checkbox"/> Limit candy, chips & ice cream
<input type="checkbox"/> Physical activity / exercise	<input type="checkbox"/> Healthy food choices	<input type="checkbox"/> Eating disorder
Accident Prevention & Guidance		
<input type="checkbox"/> Alcohol/drug/substance misuse counseling	<input type="checkbox"/> ASA use	<input type="checkbox"/> Independence
<input type="checkbox"/> Signs of depression (suicidal ideation)	<input type="checkbox"/> Gun safety	<input type="checkbox"/> Personal development
<input type="checkbox"/> Mental health (emotional support)	<input type="checkbox"/> Goals in life	<input type="checkbox"/> Aging process
<input type="checkbox"/> Diabetes management	<input type="checkbox"/> Mindful of daily movements	<input type="checkbox"/> Work or retirement activities
<input type="checkbox"/> Sex education (partner selection)	<input type="checkbox"/> Motor vehicle safety (DUI / no texting & driving)	<input type="checkbox"/> Family support, social interaction & communication
<input type="checkbox"/> Safe sex practices (condoms, contraception, HIV/AIDS)	<input type="checkbox"/> Seat belt	<input type="checkbox"/> Self-breast exam
<input type="checkbox"/> Smoking/vaping use/exposure	<input type="checkbox"/> Routine dental care	<input type="checkbox"/> Perimenopause education
Tobacco Use / Cessation		
<input type="checkbox"/> Never smoked or used tobacco products		
<input type="checkbox"/> Former smoker: # Yrs smoked ____ # Cigarettes smoked/day ____ Quit date ____		
<input type="checkbox"/> Current smoker: # Yrs smoked ____ # Cigarettes smoked/day ____		
Type used: <input type="checkbox"/> Cigarettes <input type="checkbox"/> Chewing tobacco <input type="checkbox"/> Vaping products <input type="checkbox"/> Other:		
<input type="checkbox"/> Advised to quit smoking	<input type="checkbox"/> Discussed smoking cessation medication	<input type="checkbox"/> Discussed smoking cessation strategies
Next Appointment		
<input type="checkbox"/> 1 year	<input type="checkbox"/> RTC PRN	<input type="checkbox"/> Other:

Documentation Reminders		
<input type="checkbox"/> Screening tools (TB, Depression, HEP B, etc.) are completed, dated, & reviewed by provider	<input type="checkbox"/> Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)	<input type="checkbox"/> Problem / Medication Lists updated

MA / Nurse Signature	Title	Date
Provider Signature	Title	Date

Notes (include date, time, signature, and title on all entries)
<input type="checkbox"/> Member refused the following screening/orders:

Comprehensive Health Assessment

50+ Years: Male at Birth	Actual Age: _____	Date: _____
Primary Language		
Interpreter Requested	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused Name of Interpreter: _____	
Intake		Vital Signs
Allergies / Reaction		Temp _____
Height		BP _____
Weight <input type="checkbox"/> Significant loss/gain: _____ lbs		Pulse _____
BMI Value		Resp _____
Pain	Location: _____ Scale: 0 1 2 3 4 5 6 7 8 9 10	
Cultural Needs (e.g., cultural background/traditions, religious practices, dietary preference/restrictions, and healthcare beliefs): <input type="checkbox"/> Unremarkable		
Country of Birth: <input type="checkbox"/> US <input type="checkbox"/> Other: _____ At least 1 parent born in Africa, Asia, Pacific Islands: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Dental Home	Dental visit within past 12 months: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Advance Directive Info Given/Discussed	<input type="checkbox"/> Yes <input type="checkbox"/> Refused	
Chronic Problems/Significant Conditions: <input type="checkbox"/> None <input type="checkbox"/> See Problem List <input type="checkbox"/> Asthma <input type="checkbox"/> Cancer <input type="checkbox"/> Depression <input type="checkbox"/> DM <input type="checkbox"/> Dialysis <input type="checkbox"/> Heart Disease <input type="checkbox"/> HEP B <input type="checkbox"/> HEP C <input type="checkbox"/> High Cholesterol <input type="checkbox"/> HIV <input type="checkbox"/> HTN <input type="checkbox"/> Liver Disease <input type="checkbox"/> Seizures <input type="checkbox"/> STI <input type="checkbox"/> Uses DME <input type="checkbox"/> ≥ 2 ER visits in 12 months <input type="checkbox"/> Other: _____		
Functional Limitations (check all that apply): <input type="checkbox"/> Unremarkable <input type="checkbox"/> Seeing <input type="checkbox"/> Hearing <input type="checkbox"/> Mobility <input type="checkbox"/> Communication <input type="checkbox"/> Cognition <input type="checkbox"/> Self-care		
Current Medications/Vitamins: <input type="checkbox"/> See Medication List		
Education (last grade completed): _____ Health education preference: <input type="checkbox"/> Verbal <input type="checkbox"/> Visual <input type="checkbox"/> Multimedia <input type="checkbox"/> Other: _____		
Interval History		
Diet / Nutrition	<input type="checkbox"/> Regular <input type="checkbox"/> Low calorie <input type="checkbox"/> ADA <input type="checkbox"/> Iron-rich foods <input type="checkbox"/> Other: _____	
Appetite	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
Physical Activity	<input type="checkbox"/> Inactive (little or none) <input type="checkbox"/> Some (< 2 ½ hrs/week) <input type="checkbox"/> Active (≥ 2 ½ hrs per week w/ 2 days strength training)	
Sexually active	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Multiple Partners <input type="checkbox"/> MSM	
Contraceptive Used	<input type="checkbox"/> None <input type="checkbox"/> Condoms <input type="checkbox"/> Other: _____	
Last Colonoscopy	Date: _____ <input type="checkbox"/> WNL	
Social Determinants of Health (SDOH)	<input type="checkbox"/> WNL-Stable relationships w/ social/emotional support <input type="checkbox"/> Changes in family since last visit (move, job, death) <input type="checkbox"/> Problems with housing/food/employment/incarceration <input type="checkbox"/> Family stressors: mental illness/drugs/violence/abuse	
Current Alcohol / Substance Use	<input type="checkbox"/> None <input type="checkbox"/> Alcohol	
<input type="checkbox"/> Drugs (specify):	<input type="checkbox"/> IV Drugs-Current <input type="checkbox"/> IV Drugs-Past Hx	<input type="checkbox"/> Other: _____

Name:	DOB:	MR#:	
Family History	<input type="checkbox"/> Unremarkable	<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Heart disease / HTN	<input type="checkbox"/> Lives/lived with someone HBV+	<input type="checkbox"/> Asthma	
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Cancer	<input type="checkbox"/> Other: _____	
Immunization History / Date	<input type="checkbox"/> None <input type="checkbox"/> See CAIR	<input type="checkbox"/> Tdap:	
<input type="checkbox"/> COVID #1: <input type="checkbox"/> COVID #2:	<input type="checkbox"/> Influenza:	<input type="checkbox"/> Zoster:	
<input type="checkbox"/> COVID Booster(s):	<input type="checkbox"/> MMR: <input type="checkbox"/> Exempt (DOB <1957 & non-healthcare worker)	<input type="checkbox"/> Varicella: <input type="checkbox"/> Exempt (non-healthcare worker)	
<input type="checkbox"/> Hepatitis B:	<input type="checkbox"/> Pneumococcal:	<input type="checkbox"/> Other: _____	
USPSTF Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/Orders/AG)
Abdominal Aortic Aneurism	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Adverse Childhood Experiences (screen at least once in adulthood at earliest opportunity)	<input type="checkbox"/> ACEs	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol Misuse	<input type="checkbox"/> SHA , <input type="checkbox"/> CRAFFT , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Cognitive Health (Start at 65 yrs old) Score: _____	<input type="checkbox"/> MINI-COG , <input type="checkbox"/> AD8 , <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Colorectal Cancer	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Depression Score: _____	<input type="checkbox"/> PHQ2 , <input type="checkbox"/> PHQ9 , <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Drug Misuse	<input type="checkbox"/> SHA , <input type="checkbox"/> CRAFFT , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Dyslipidemia	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Hep B (Test all 18 yrs and older at least once at earliest opportunity)	<input type="checkbox"/> CDC HEP Risk , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Hep C (Test all 18-79 yrs old at least once at earliest opportunity)	<input type="checkbox"/> CDC HEP Risk , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
HIV (Test all 15-65 yrs old at least once at earliest opportunity)	<input type="checkbox"/> SHA , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Lung Cancer	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Obesity	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Sexually Transmitted Infections	<input type="checkbox"/> SHA , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
SDOH	<input type="checkbox"/> SDOH , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco Use	<input type="checkbox"/> SHA , <input type="checkbox"/> CRAFFT , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis Exposure	<input type="checkbox"/> TB Risk Assessment , <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Physical Examination		WNL	
General appearance	Well-nourished & developed No abuse/neglect evident	<input type="checkbox"/>	
Head	No lesions	<input type="checkbox"/>	
Eyes	PERRLA, conjunctivae & sclerae clear Vision grossly normal	<input type="checkbox"/>	
Ears	Canals clear, TMs normal Hearing grossly normal	<input type="checkbox"/>	
Nose	Passages clear, MM pink, no lesions	<input type="checkbox"/>	
Teeth	No visible cavities, grossly normal	<input type="checkbox"/>	

Comprehensive Health Assessment

Mouth / Pharynx	Oral mucosa pink, no lesions	<input type="checkbox"/>
Neck	Supple, no masses, thyroid not enlarged	<input type="checkbox"/>
Chest	Symmetrical, no masses	<input type="checkbox"/>
Heart	No organic murmurs, regular rhythm	<input type="checkbox"/>
Lungs	Clear to auscultation bilaterally	<input type="checkbox"/>
Abdomen	Soft, no masses, liver & spleen normal	<input type="checkbox"/>
Genitalia	Grossly normal	<input type="checkbox"/>
Male	Circ /uncircumcised, testes in scrotum Prostate Exam / Rectal	<input type="checkbox"/>
Femoral pulses	Present & equal	<input type="checkbox"/>
Extremities	No deformities, full ROM	<input type="checkbox"/>
Lymph nodes	Not enlarged	<input type="checkbox"/>
Back	No scoliosis	<input type="checkbox"/>
Skin	Clear, no significant lesions	<input type="checkbox"/>
Neurologic	Alert, no gross sensory or motor deficit	<input type="checkbox"/>
Subjective / Objective		
Assessment		
Plan		
Referrals		
<input type="checkbox"/> Dentist	<input type="checkbox"/> Optometrist / Ophthalmologist	<input type="checkbox"/> Dietician / Nutritionist
<input type="checkbox"/> Drug / ETOH Tx rehab	<input type="checkbox"/> Behavioral health	<input type="checkbox"/> Tobacco cessation class
<input type="checkbox"/> Other:		
Orders		
<input type="checkbox"/> COVID 19 vaccine / booster	<input type="checkbox"/> Hep B Panel (if high risk)	<input type="checkbox"/> CBC / Basic metabolic panel
<input type="checkbox"/> Hep B vaccine (if not up to date)	<input type="checkbox"/> Hep C Antibody test (if high risk)	<input type="checkbox"/> Hct / Hgb <input type="checkbox"/> Lipid panel
<input type="checkbox"/> Influenza	<input type="checkbox"/> Chlamydia <input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Low to moderate dose statin
<input type="checkbox"/> MMR (if not up to date)	<input type="checkbox"/> HIV (if high risk) <input type="checkbox"/> Herpes	<input type="checkbox"/> PPD skin test <input type="checkbox"/> QFT
<input type="checkbox"/> Pneumococcal	<input type="checkbox"/> Syphilis <input type="checkbox"/> Trichomonas	<input type="checkbox"/> CXR <input type="checkbox"/> Urinalysis
<input type="checkbox"/> Tdap	<input type="checkbox"/> gFOBT or Fit <input type="checkbox"/> Colonoscopy	<input type="checkbox"/> ECG <input type="checkbox"/> COVID 19 test
<input type="checkbox"/> Varicella (if not up to date)	<input type="checkbox"/> Low Dose CT (20-pack year smoking history & currently smoke or have quit within past 15 years)	<input type="checkbox"/> Fasting plasma glucose <input type="checkbox"/> Oral glucose tolerance test
<input type="checkbox"/> Zoster	<input type="checkbox"/> AAA Ultrasound (65 to 75 who have ever smoked >100 cigarettes in lifetime)	<input type="checkbox"/> HbA1C <input type="checkbox"/> PSA
<input type="checkbox"/> Other:		

Name: _____ DOB: _____ MR#: _____

Anticipatory Guidance (AG) / Education (✓ if discussed)		
Diet, Nutrition & Exercise		
<input type="checkbox"/> Weight control / obesity	<input type="checkbox"/> Vegetables, fruits	<input type="checkbox"/> Lean protein
<input type="checkbox"/> Whole grains / iron-rich foods	<input type="checkbox"/> Limit fatty, sugary & salty foods	<input type="checkbox"/> Limit candy, chips & ice cream
<input type="checkbox"/> Physical activity / exercise	<input type="checkbox"/> Healthy food choices	<input type="checkbox"/> Eating disorder
Accident Prevention & Guidance		
<input type="checkbox"/> Alcohol/drug/substance misuse counseling	<input type="checkbox"/> Avoid risk-taking behavior	<input type="checkbox"/> Independence
<input type="checkbox"/> Signs of depression (suicidal ideation)	<input type="checkbox"/> Gun safety	<input type="checkbox"/> Personal development
<input type="checkbox"/> Diabetes management	<input type="checkbox"/> Violent behavior	<input type="checkbox"/> Goals in life
<input type="checkbox"/> Sex education (partner selection)	<input type="checkbox"/> Mindful of daily movements	<input type="checkbox"/> Work or retirement activities
<input type="checkbox"/> Safe sex practices (condoms, contraception, HIV/AIDS)	<input type="checkbox"/> Motor vehicle safety (DUI / no texting & driving)	<input type="checkbox"/> Family support, social interaction & communication
<input type="checkbox"/> Smoking/vaping use/exposure	<input type="checkbox"/> Seat belt	<input type="checkbox"/> Testicular self-exam
<input type="checkbox"/> Routine dental care	<input type="checkbox"/> Safety helmet	<input type="checkbox"/> Aging process
Tobacco Use / Cessation		
<input type="checkbox"/> Never smoked or used tobacco products		
<input type="checkbox"/> Former smoker: # Yrs smoked ____ # Cigarettes smoked/day ____ Quit date ____		
<input type="checkbox"/> Current smoker: # Yrs smoked ____ # Cigarettes smoked/day ____		
Type used: <input type="checkbox"/> Cigarettes <input type="checkbox"/> Chewing tobacco <input type="checkbox"/> Vaping products <input type="checkbox"/> Other:		
<input type="checkbox"/> Advised to quit smoking	<input type="checkbox"/> Discussed smoking cessation medication	<input type="checkbox"/> Discussed smoking cessation strategies
Next Appointment		
<input type="checkbox"/> 1 year	<input type="checkbox"/> RTC PRN	<input type="checkbox"/> Other:

Documentation Reminders		
<input type="checkbox"/> Screening tools (TB, Depression, HEP B, etc.) are completed, dated, & reviewed by provider	<input type="checkbox"/> Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)	<input type="checkbox"/> Problem / Medication Lists updated

MA / Nurse Signature	Title	Date
Provider Signature	Title	Date

Notes (include date, time, signature, and title on all entries)
<input type="checkbox"/> Member refused the following screening/orders: