

COMPREHENSIVE HEALTH ASSESSMENT FORMS

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COMPREHENSIVE HEALTH ASSESSMENT FORMS

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Comprehensive Health Assessment

Under 1 Month Old	Actual Age: _____	Date: _____
Medical Record #		
Gender	<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	Vital Signs	
Allergies	Temp	
Height	Pulse	
Weight	Resp	
Head Circumference		
Birth History	Birth Weight: _____	Gestation: _____
Delivery	<input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section	Complications <input type="checkbox"/> Yes <input type="checkbox"/> No
OB/GYN Provider		
Post-Partum Appointment Date		
Cord	<input type="checkbox"/> Absent <input type="checkbox"/> Present <input type="checkbox"/> Redness/swelling <input type="checkbox"/> Yellow drainage	
Chronic Problems/Significant Conditions: <input type="checkbox"/> See Problem List		
Current Medications/Vitamins: <input type="checkbox"/> See Medication List		
Interval History		
Nutrition	<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 (2-4 hours) <input type="checkbox"/> Abnormal	
Sleeping 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	<input type="checkbox"/> HTN	<input type="checkbox"/> Asthma
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Cancer	<input type="checkbox"/> Family Hx of unexpected or sudden death < 50 YO
<input type="checkbox"/> Childhood hearing impairment	<input type="checkbox"/> Other: _____	
Psychosocial & Behavioral Assessment, Family/Social Factors	<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: _____

AAP Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/Orders/AG)
Maternal Depression	<input type="checkbox"/> EPDS, <input type="checkbox"/> PHQ-9, <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Intimate Partner Violence	<input type="checkbox"/> PEARLS, <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Psychosocial / Behavioral	<input type="checkbox"/> PAPE, <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"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis Exposure	<input type="checkbox"/> TB Risk Assessment, <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Growth and Development			
<input type="checkbox"/> Prone, lifts head briefly	<input type="checkbox"/> Turns head side to side	<input type="checkbox"/> Responds to sound	
<input type="checkbox"/> Moro reflex	<input type="checkbox"/> Blinks at bright light	<input type="checkbox"/> Keeps hands in a fist	
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 / Palate	Oral mucosa pink, no cleft lip or palate	<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"/>	
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

1 to 2 Months Old	Actual Age: _____	Date: _____
Medical Record #		
Gender	<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	Vital Signs	
Allergies	Temp	
Height	Pulse	
Weight	Resp	
Head Circumference		
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10	
Chronic Problems/Significant Conditions: <input type="checkbox"/> See Problem List		
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	<input type="checkbox"/> HTN	<input type="checkbox"/> Asthma
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Cancer	<input type="checkbox"/> Family Hx of unexpected or sudden death < 50 YO
<input type="checkbox"/> Other: _____		
Psychosocial & Behavioral Assessment, Family/Social Factors	<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:

AAP Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/Orders/AG)
Maternal Depression	<input type="checkbox"/> EPDS, <input type="checkbox"/> PHQ-9, <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Intimate Partner Violence	<input type="checkbox"/> PEARLS, <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Psychosocial / Behavioral	<input type="checkbox"/> PSC, <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"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis Exposure	<input type="checkbox"/> TB Risk Assessment, <input type="checkbox"/> H&P, <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: _____
Medical Record #		
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Accompanied by	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other:	
Primary Language		
Interpreter Requested	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused	
Name of Interpreter		
Intake	Vital Signs	
Allergies	Temp	
Height	Pulse	
Weight	Resp	
Head Circumference		
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10	
Chronic Problems/Significant Conditions: <input type="checkbox"/> See Problem List		
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 <input type="checkbox"/> HTN <input type="checkbox"/> Asthma <input type="checkbox"/> High cholesterol <input type="checkbox"/> Cancer <input type="checkbox"/> Family Hx of unexpected or sudden death < 50 YO <input type="checkbox"/> Other: _____	
Psychosocial & Behavioral Assessment, Family/Social Factors	<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: _____

AAP Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/Orders/AG)
Anemia	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Maternal Depression	<input type="checkbox"/> EPDS , <input type="checkbox"/> PHQ-9 , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Intimate Partner Violence	<input type="checkbox"/> PEARLS , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Psychosocial / Behavioral	<input type="checkbox"/> PSC , <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"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis Exposure	<input type="checkbox"/> TB Risk Screener , <input type="checkbox"/> H&P, <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"/>	
Subjective / Objective			

Comprehensive Health Assessment

5 to 6 Months Old	Actual Age: _____	Date: _____
Medical Record #		
Gender	<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		Vital Signs
Allergies		Temp _____
Height		Pulse _____
Weight		Resp _____
Head Circumference		
Pain	Location: _____ Scale: 0 1 2 3 4 5 6 7 8 9 10	
Dental Provider	Last visit date: _____	
Chronic Problems/Significant Conditions: <input type="checkbox"/> See Problem List		
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	
Fluoridated Water Supply	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Fluoride Varnish	Date last applied: _____	
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	<input type="checkbox"/> HTN	<input type="checkbox"/> Asthma
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Cancer	<input type="checkbox"/> Family Hx of unexpected or sudden death < 50 YO
<input type="checkbox"/> Other: _____		
Psychosocial & Behavioral Assessment, Family/Social Factors	<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:

AAP Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/Orders/AG)
Blood Lead	<input type="checkbox"/> Lead Assessment , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Maternal Depression	<input type="checkbox"/> EPDS , <input type="checkbox"/> PHQ-9 , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Intimate Partner Violence	<input type="checkbox"/> PEARLS , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Psychosocial / Behavioral	<input type="checkbox"/> PSC , <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"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis Exposure	<input type="checkbox"/> TB Risk Assessment , <input type="checkbox"/> H&P, <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	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 (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"/>	
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"/>	

Comprehensive Health Assessment

7 to 9 Months Old	Actual Age: _____	Date: _____
Medical Record #		
Gender	<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		Vital Signs
Allergies		Temp _____
Height		Pulse _____
Weight		Resp _____
Head Circumference		
Pain	Location: _____ Scale: 0 1 2 3 4 5 6 7 8 9 10	
Dental Provider	Last visit date: _____	
Chronic Problems/Significant Conditions: <input type="checkbox"/> See Problem List		
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	
Fluoridated Water Supply	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Fluoride Varnish	Date last applied: _____	
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	<input type="checkbox"/> HTN	<input type="checkbox"/> Asthma
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Cancer	<input type="checkbox"/> Family Hx of unexpected or sudden death < 50 YO
<input type="checkbox"/> Other: _____		
Psychosocial & Behavioral Assessment, Family/Social Factors	<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: _____

AAP Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/Orders/AG)
Blood Lead	<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 (9 Months)	<input type="checkbox"/> ASQ-3 , <input type="checkbox"/> SWYC , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Intimate Partner Violence	<input type="checkbox"/> PEARLS , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Psychosocial / Behavioral	<input type="checkbox"/> PSC , <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"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis Exposure	<input type="checkbox"/> TB Risk Assessment , <input type="checkbox"/> H&P, <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	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"/>
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

10 to 11 Months Old	Actual Age: _____	Date: _____
Medical Record #		
Gender	<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	Vital Signs	
Allergies	Temp	
Height	Pulse	
Weight	Resp	
Head Circumference		
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10	
Dental Provider	Last visit date: _____	
Chronic Problems/Significant Conditions: <input type="checkbox"/> See Problem List		
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	
Fluoridated Water Supply	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Fluoride Varnish	Date last applied: _____	
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	<input type="checkbox"/> HTN	<input type="checkbox"/> Asthma
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Cancer	<input type="checkbox"/> Family Hx of unexpected or sudden death < 50 YO
<input type="checkbox"/> Other: _____		
Psychosocial & Behavioral Assessment, Family/Social Factors	<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: _____

AAP Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/Orders/AG)
Blood Lead	<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"/>
Hepatitis B	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Intimate Partner Violence	<input type="checkbox"/> PEARLS , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Psychosocial / Behavioral	<input type="checkbox"/> PSC , <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"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis Exposure	<input type="checkbox"/> TB Risk Assessment , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Growth and Development			
<input type="checkbox"/> Pulls self to standing	<input type="checkbox"/> Walks with help	<input type="checkbox"/> Drop object in cup	
<input type="checkbox"/> Stands holding on	<input type="checkbox"/> Plays pat-a-cake	<input type="checkbox"/> Says "mama" or "dada"	
<input type="checkbox"/> Thumb-finger grasp	<input type="checkbox"/> Holds cup to drink	<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 (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"/>	
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			

Comprehensive Health Assessment

12 to 15 Months Old	Actual Age: _____	Date: _____
Medical Record #		
Gender	<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		Vital Signs
Allergies		Temp _____
Height		Pulse _____
Weight		Resp _____
Head Circumference		
Pain	Location: _____ Scale: 0 1 2 3 4 5 6 7 8 9 10	
Dental Provider	Last visit date: _____	
Chronic Problems/Significant Conditions: <input type="checkbox"/> See Problem List		
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:	
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"/> Night time fears	
Fluoridated Water Supply	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Fluoride Varnish	Date last applied: _____	
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	<input type="checkbox"/> HTN	<input type="checkbox"/> Asthma
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Cancer	<input type="checkbox"/> Family Hx of unexpected or sudden death < 50 YO
<input type="checkbox"/> Other: _____		
Psychosocial & Behavioral Assessment, Family/Social Factors	<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:

AAP Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/Orders/AG)
Anemia	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Blood Lead	<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"/>
Hepatitis B	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Intimate Partner Violence	<input type="checkbox"/> PEARLS , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Psychosocial / Behavioral	<input type="checkbox"/> PSC , <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"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis Exposure	<input type="checkbox"/> TB Risk Assessment , <input type="checkbox"/> H&P, <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 (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"/>
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

16 to 23 Months Old	Actual Age: _____	Date: _____
Medical Record #		
Gender	<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	Vital Signs	
Allergies	Temp	
Height	Pulse	
Weight	Resp	
Head Circumference		
Pain	Location: _____ Scale: 0 1 2 3 4 5 6 7 8 9 10	
Dental Provider	Last visit date: _____	
Chronic Problems/Significant Conditions: <input type="checkbox"/> See Problem List		
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:	
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"/> Night time fears	
Fluoridated Water Supply	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Fluoride Varnish	Date last applied: _____	
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	<input type="checkbox"/> HTN	<input type="checkbox"/> Asthma
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Cancer	<input type="checkbox"/> Family Hx of unexpected or sudden death < 50 YO
<input type="checkbox"/> Other: _____		
Psychosocial & Behavioral Assessment, Family/Social Factors	<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: _____

AAP Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/Orders/AG)
Anemia	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Autism Disorder (18 Months)	<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	<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 (18 Months)	<input type="checkbox"/> ASQ-3, <input type="checkbox"/> SWYC, <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Intimate Partner Violence	<input type="checkbox"/> PEARLS, <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Psychosocial / Behavioral	<input type="checkbox"/> PSC, <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"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis Exposure	<input type="checkbox"/> TB Risk Assessment, <input type="checkbox"/> H&P, <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 (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"/>	
Hips	Good abduction, leg length equal	<input type="checkbox"/>	
Femoral pulses	Normal	<input type="checkbox"/>	
Extremities	No deformities, full ROM	<input type="checkbox"/>	

Comprehensive Health Assessment

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"/> Hib (if not up to date)	<input type="checkbox"/> Blood Lead	<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"/> IPV (if not up to date)	<input type="checkbox"/> Rx Fluoride drops / chewable tabs 0.25-0.50 mg QD (PRN through age 4)	<input type="checkbox"/> Urinalysis
<input type="checkbox"/> ECG	<input type="checkbox"/> COVID 19 test	<input type="checkbox"/> Fluoride varnish application
<input type="checkbox"/> Other:		

Name:

DOB:

Anticipatory Guidance (AG) / Education (✓ if discussed)		
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"/> 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"/> 1 year	<input type="checkbox"/> RTC PRN	<input type="checkbox"/> Other:

Documentation Reminders		
<input type="checkbox"/> Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed by provider	<input type="checkbox"/> 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)

Comprehensive Health Assessment

2 Years Old	Actual Age: _____	Date: _____
Medical Record #		
Gender	<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		Vital Signs
Allergies		Temp _____
Height		Pulse _____
Weight		Resp _____
BMI Value		BMI % _____
Pain	Location: _____ Scale: 0 1 2 3 4 5 6 7 8 9 10	
Dental Provider	Last visit date: _____	
Chronic Problems/Significant Conditions: <input type="checkbox"/> See Problem List		
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:	
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	
Fluoridated Water Supply	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Fluoride Varnish	Date last applied: _____	
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	<input type="checkbox"/> HTN	<input type="checkbox"/> Asthma
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Cancer	<input type="checkbox"/> Family Hx of unexpected or sudden death < 50 YO
<input type="checkbox"/> Other: _____		
Psychosocial & Behavioral Assessment, Family/Social Factors	<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:

AAP Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/Orders/AG)
Anemia	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Autism Disorder	<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	<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	<input type="checkbox"/> ASQ-3, <input type="checkbox"/> SWYC, <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"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Intimate Partner Violence	<input type="checkbox"/> PEARLS, <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Psychosocial / Behavioral	<input type="checkbox"/> PSC, <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"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis Exposure	<input type="checkbox"/> TB Risk Assessment, <input type="checkbox"/> H&P, <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 (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"/>	
Hips	Good abduction	<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"/> 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 0.25-0.50 mg QD (PRN through age 4)	<input type="checkbox"/> Fluoride varnish application
<input type="checkbox"/> Other:		

Name:

DOB:

Anticipatory Guidance (AG) / Education (✓ if discussed)		
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"/> 1 year	<input type="checkbox"/> RTC PRN	<input type="checkbox"/> Other:

Documentation Reminders		
<input type="checkbox"/> Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed 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)

Comprehensive Health Assessment

30 Months Old	Actual Age: _____	Date: _____
Medical Record #		
Gender	<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		Vital Signs
Allergies		Temp
Height		Pulse
Weight		Resp
BMI Value		BMI %
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10	
Dental Provider	Last visit date: _____	
Chronic Problems/Significant Conditions: <input type="checkbox"/> See Problem List		
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:	
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	
Fluoridated Water Supply	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Fluoride Varnish	Date last applied: _____	
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	<input type="checkbox"/> HTN	<input type="checkbox"/> Asthma
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Cancer	<input type="checkbox"/> Family Hx of unexpected or sudden death < 50 YO
<input type="checkbox"/> Other: _____		
Psychosocial & Behavioral Assessment, Family/Social Factors	<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: _____

AAP Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/Orders/AG)
Anemia	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Blood Lead	<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	<input type="checkbox"/> ASQ-3 , <input type="checkbox"/> SWYC , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Intimate Partner Violence	<input type="checkbox"/> PEARLS , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Psychosocial / Behavioral	<input type="checkbox"/> PSC , <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"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis Exposure	<input type="checkbox"/> TB Risk Assessment , <input type="checkbox"/> H&P, <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 (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"/>
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"/>

Comprehensive Health Assessment

3 Years Old	Actual Age: _____	Date: _____
Medical Record #		
Gender	<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		Vital Signs
Allergies		Temp
Height		BP
Weight		Pulse
BMI Value		Resp
BMI %		
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	
Dental Provider	Last visit date: _____	
Chronic Problems/Significant Conditions: <input type="checkbox"/> See Problem List		
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:	
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	
Fluoridated Water Supply	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Fluoride Varnish	Date last applied: _____	
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	<input type="checkbox"/> HTN	<input type="checkbox"/> Asthma
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Cancer	<input type="checkbox"/> Family Hx of unexpected or sudden death < 50 YO
<input type="checkbox"/> Other: _____		

Name: _____

DOB: _____

Psychosocial & Behavioral Assessment, Family/Social Factors	<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)
Anemia	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Blood Lead	<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"/>
Dyslipidemia	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Intimate Partner Violence	<input type="checkbox"/> PEARLS , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Psychosocial / Behavioral	<input type="checkbox"/> PSC , <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"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis Exposure	<input type="checkbox"/> TB Risk Assessment , <input type="checkbox"/> H&P, <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			
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 (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"/>	
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- 0.50 mg QD (PRN through age 4)	<input type="checkbox"/> Fluoride varnish application
<input type="checkbox"/> Other:		

Name:

DOB:

Anticipatory Guidance (AG) / Education (✓ if discussed)		
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"/> 1 year	<input type="checkbox"/> RTC PRN	<input type="checkbox"/> Other:

Documentation Reminders		
<input type="checkbox"/> Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed 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)

Comprehensive Health Assessment

4 to 5 Years Old	Actual Age: _____	Date: _____
Medical Record #		
Gender	<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	Vital Signs	
Allergies	Temp	
Height	BP	
Weight	Pulse	
BMI Value	Resp	
BMI %		
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
Dental Provider	Last visit date: _____	
Chronic Problems/Significant Conditions: <input type="checkbox"/> See Problem List		
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:	
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	
Fluoridated Water Supply	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Fluoride Varnish	Date last applied: _____	
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	<input type="checkbox"/> HTN	<input type="checkbox"/> Asthma
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Cancer	<input type="checkbox"/> Family Hx of unexpected or sudden death < 50 YO
<input type="checkbox"/> Other: _____		

Name: _____

DOB: _____

Psychosocial & Behavioral Assessment, Family/Social Factors	<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)
Anemia	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Blood Lead	<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"/>
Dyslipidemia	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Intimate Partner Violence	<input type="checkbox"/> PEARLS , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Psychosocial / Behavioral	<input type="checkbox"/> PSC , <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"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis Exposure	<input type="checkbox"/> TB Risk Assessment , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Growth and Development / School Progress			
<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 (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"/>	

Comprehensive Health Assessment

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"/> 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 0.25-0.50 mg QD (PRN through age 4)	<input type="checkbox"/> Urinalysis at 5 years
<input type="checkbox"/> Fluoride varnish application		<input type="checkbox"/> ECG
<input type="checkbox"/> COVID 19 test		<input type="checkbox"/> COVID 19 test
<input type="checkbox"/> Other:		

Name:

DOB:

Anticipatory Guidance (AG) / Education (✓ if discussed)		
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"/> Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed 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)

Comprehensive Health Assessment

6 to 8 Years Old	Actual Age: _____	Date: _____
Medical Record #		
Gender	<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		Vital Signs
Allergies		Temp _____
Height		BP _____
Weight		Pulse _____
BMI Value		Resp _____
BMI %		
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	
Dental Provider	Last visit date: _____	
Chronic Problems/Significant Conditions: <input type="checkbox"/> See Problem List		
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:	
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	<input type="checkbox"/> HTN	<input type="checkbox"/> Asthma
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Cancer	<input type="checkbox"/> Family Hx of unexpected or sudden death < 50 YO
<input type="checkbox"/> Other: _____		
Psychosocial & Behavioral Assessment, Family/ Social Factors	<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: _____

AAP Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/Orders/AG)
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"/>
Dyslipidemia	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Intimate Partner Violence	<input type="checkbox"/> PEARLS , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Psychosocial / Behavioral	<input type="checkbox"/> PSC , <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"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis Exposure	<input type="checkbox"/> TB Risk Assessment , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Growth and Development / School Progress			
<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 (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"/>

Comprehensive Health Assessment

9 to 12 Years Old	Actual Age: _____	Date: _____
Medical Record #		
Gender	<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 Interpreter Name: _____	
Intake		Vital Signs
Allergies		Temp _____
Height		BP _____
Weight		Pulse _____
BMI Value		Resp _____
BMI %		
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	
Dental Provider	Last visit date: _____	
Chronic Problems/Significant Conditions: <input type="checkbox"/> See Problem List		
Current Medications/Vitamins: <input type="checkbox"/> See Medication List		
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 (≥ 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 (or past Hx)	<input type="checkbox"/> Tobacco / Vape Packs/day:
Family History	<input type="checkbox"/> Unremarkable <input type="checkbox"/> Diabetes	
<input type="checkbox"/> Heart disease	<input type="checkbox"/> HTN	<input type="checkbox"/> Asthma
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Cancer	<input type="checkbox"/> Family Hx of unexpected or sudden death < 50 YO
<input type="checkbox"/> Other:		

Name: _____

DOB: _____

Psychosocial & Behavioral Assessment, Family/Social Factors	<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)
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"/>
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"/>
Depression	<input type="checkbox"/> PHQ-9A , <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"/>
Hepatitis B	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
HIV	<input type="checkbox"/> SHA , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Intimate Partner Violence	<input type="checkbox"/> PEARLS , <input type="checkbox"/> PEARLS-12&UP <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Psychosocial / Behavioral	<input type="checkbox"/> PSC , <input type="checkbox"/> PSC-Y , <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"/>
Sudden Cardiac Arrest	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Suicide	<input type="checkbox"/> ASQ , <input type="checkbox"/> PHQ-9A , <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco Use / Exposure	<input type="checkbox"/> SHA , <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"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Growth and Development / School Progress			
<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"/>	
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"/>	

Comprehensive Health Assessment

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 YO)
<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 YO)	<input type="checkbox"/> HIV	<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"/> Other:		

Name:

DOB:

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"/> 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 Cessation	Quit Date:	
<input type="checkbox"/> Advised to quit smoking	<input type="checkbox"/> Discuss smoking cessation medication	<input type="checkbox"/> Discuss smoking cessation strategies
Next Appointment		
<input type="checkbox"/> 1 year	<input type="checkbox"/> RTC PRN	<input type="checkbox"/> Other:
Documentation Reminders		
<input type="checkbox"/> Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed 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)		

Comprehensive Health Assessment

13 to 16 Years Old	Actual Age: _____	Date: _____
Medical Record #		
Gender	<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 Interpreter Name: _____	
Intake	Vital Signs	
Allergies	Temp	
Height	BP	
Weight	Pulse	
BMI Value	Resp	
BMI %		
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	
Dental Provider	Last visit date: _____	
Chronic Problems/Significant Conditions: <input type="checkbox"/> See Problem List		
Current Medications/Vitamins: <input type="checkbox"/> See Medication List		
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 (≥ 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 (or past Hx)	<input type="checkbox"/> Tobacco / Vape Packs/day:
Family History	<input type="checkbox"/> Unremarkable <input type="checkbox"/> Diabetes	
<input type="checkbox"/> Heart disease	<input type="checkbox"/> HTN	<input type="checkbox"/> Asthma
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Cancer	<input type="checkbox"/> Family Hx of unexpected or sudden death < 50 YO
<input type="checkbox"/> Other:		

Name: _____

DOB: _____

Psychosocial & Behavioral Assessment, Family/Social Factors	<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)
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"/>
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"/>
Depression	<input type="checkbox"/> PHQ-9A , <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"/>
Hepatitis B	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
HIV	<input type="checkbox"/> SHA , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Intimate Partner Violence	<input type="checkbox"/> PEARLS , <input type="checkbox"/> PEARLS-12&UP , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Psychosocial / Behavioral	<input type="checkbox"/> PSC , <input type="checkbox"/> PSC-Y , <input type="checkbox"/> HEADSSS , <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"/>
Sudden Cardiac Arrest	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Suicide	<input type="checkbox"/> ASQ , <input type="checkbox"/> PHQ-9A , <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco Use / Exposure	<input type="checkbox"/> SHA , <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"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Growth and Development / School Progress			
<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"/>
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/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"/> 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	<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"/> Other:		

Name:

DOB:

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"/> 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 Cessation Quit Date:		
<input type="checkbox"/> Advised to quit smoking	<input type="checkbox"/> Discuss smoking cessation medication	<input type="checkbox"/> Discuss smoking cessation strategies
Next Appointment		
<input type="checkbox"/> 1 year	<input type="checkbox"/> RTC PRN	<input type="checkbox"/> Other:

Documentation Reminders		
<input type="checkbox"/> Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed 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)

Comprehensive Health Assessment

17 to 20 Years Old	Actual Age: _____ Date: _____
Medical Record #	
Gender	<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 Interpreter Name: _____
Intake	Vital Signs
Allergies	Temp _____
Height	BP _____
Weight	Pulse _____
BMI Value	Resp _____
BMI %	
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
Dental Provider	Last visit date: _____
Advance Directive Info given/discussed	<input type="checkbox"/> Yes <input type="checkbox"/> Refused Starting at 18 Years Old
Chronic Problems/Significant Conditions: <input type="checkbox"/> See Problem List	
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 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
Weight <input type="checkbox"/> Loss <input type="checkbox"/> Gain	_____ lbs <input type="checkbox"/> Intentional <input type="checkbox"/> Unintentional
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 (or past Hx) <input type="checkbox"/> Tobacco / Vape Packs/day:

Name: _____

DOB: _____

Family History	<input type="checkbox"/> Unremarkable	<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Heart disease	<input type="checkbox"/> HTN	<input type="checkbox"/> Asthma	
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Cancer	<input type="checkbox"/> Family Hx of unexpected or sudden death < 50 YO	
<input type="checkbox"/> Other: _____			
Psychosocial & Behavioral Assessment, Family/Social Factors	<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)	
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"/>
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"/>
Depression	<input type="checkbox"/> PHQ-9A , <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"/>
Hepatitis B	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis C	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
HIV	<input type="checkbox"/> SHA , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Intimate Partner Violence	<input type="checkbox"/> ACEs , <input type="checkbox"/> PEARLS , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Psychosocial / Behavioral	<input type="checkbox"/> PSC-Y , <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"/>
Sudden Cardiac Arrest	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Suicide	<input type="checkbox"/> ASQ , <input type="checkbox"/> PHQ-9A , <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco Use / Exposure	<input type="checkbox"/> SHA , <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"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Growth and Development / School Progress			
<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"/>
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 (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 (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 (at least once > 18 YO)	<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 YO)
<input type="checkbox"/> Influenza vaccine	<input type="checkbox"/> Chlamydia	<input type="checkbox"/> PPD skin test
<input type="checkbox"/> Meningococcal vaccine (if not up to date)	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> QFT
<input type="checkbox"/> MMR (if not up to date)	<input type="checkbox"/> HIV	<input type="checkbox"/> CXR
<input type="checkbox"/> MMR (if not up to date)	<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"/> MMR (if not up to date)	<input type="checkbox"/> Trichomonas	<input type="checkbox"/> COVID 19 test
<input type="checkbox"/> Tdap	<input type="checkbox"/> Other:	

Name:

DOB:

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"/> 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 Cessation	Quit Date:	
<input type="checkbox"/> Advised to quit smoking	<input type="checkbox"/> Discuss smoking cessation medication	<input type="checkbox"/> Discuss smoking cessation strategies
Next Appointment		
<input type="checkbox"/> 1 year	<input type="checkbox"/> RTC PRN	<input type="checkbox"/> Other:

Documentation Reminders		
<input type="checkbox"/> Staying Healthy Assessment / IHEBA forms reviewed, completed, dated & signed 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)

Comprehensive Health Assessment

21 to 39 Years: Female	Actual Age:	Date:
Medical Record #		
Primary Language		
Interpreter Requested	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused	
Name of Interpreter		
Intake	Vital Signs	
Allergies	Temp	
Height	BP	
Weight	Pulse	
BMI Value	Resp	
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10	
Dental Provider	Last visit date:	
Advance Directive Info Given/Discussed	<input type="checkbox"/> Yes <input type="checkbox"/> Refused	
Chronic Problems/Significant Conditions: <input type="checkbox"/> See Problem List		
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)		
Limitations (physical or mental):		
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)	
Weight <input type="checkbox"/> Loss <input type="checkbox"/> Gain	_____ lbs <input type="checkbox"/> Intentional <input type="checkbox"/> Unintentional	
LMP:	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:	
Last PAP	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 (or past Hx)	<input type="checkbox"/> Tobacco / Vape Packs/day:
Family History	<input type="checkbox"/> None <input type="checkbox"/> Diabetes	
<input type="checkbox"/> Heart disease	<input type="checkbox"/> HTN	<input type="checkbox"/> Hip fracture
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Cancer	<input type="checkbox"/> Other:

Name:

DOB:

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"/> Varicella:	
<input type="checkbox"/> COVID Booster(s):	<input type="checkbox"/> MMR:	<input type="checkbox"/> Zoster:	
<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)	
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	<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"/>
Hepatitis B	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis C	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
HIV	<input type="checkbox"/> SHA , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Intimate Partner Violence	<input type="checkbox"/> HARK , <input type="checkbox"/> HITS , <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"/>
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"/> H&P, <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"/>	
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

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	<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 <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"/> PAP	<input type="checkbox"/> Bone Density Test
<input type="checkbox"/> Other:		

Name:

DOB:

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 Cessation

Quit Date:

<input type="checkbox"/> Advised to quit smoking	<input type="checkbox"/> Discuss smoking cessation medication	<input type="checkbox"/> Discuss 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"/> Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed 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)

Comprehensive Health Assessment

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 at risk)	<input type="checkbox"/> Low to moderate dose statin
<input type="checkbox"/> Influenza vaccine	<input type="checkbox"/> Hep C Antibody test	<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 <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:

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 Cessation	Quit Date:	
<input type="checkbox"/> Advised to quit smoking	<input type="checkbox"/> Discuss smoking cessation medication	<input type="checkbox"/> Discuss smoking cessation strategies
Next Appointment		
<input type="checkbox"/> 1 year	<input type="checkbox"/> RTC PRN	<input type="checkbox"/> Other:

Documentation Reminders		
<input type="checkbox"/> Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed 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)

Comprehensive Health Assessment

40 to 49 Years: Female	Actual Age:	Date:
Medical Record #		
Primary Language		
Interpreter Requested	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused Interpreter Name:	
Intake	Vital Signs	
Allergies	Temp	
Height	BP	
Weight	Pulse	
BMI Value	Resp	
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10	
Dental Provider	Last visit date:	
Advance Directive Info Given/Discussed	<input type="checkbox"/> Yes <input type="checkbox"/> Refused	
Chronic Problems/Significant Conditions: <input type="checkbox"/> See Problem List		
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)		
Limitations (physical or mental):		
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)	
Weight <input type="checkbox"/> Loss <input type="checkbox"/> Gain	_____ lbs	<input type="checkbox"/> Intentional <input type="checkbox"/> Unintentional
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	Date:	<input type="checkbox"/> WNL
Last Mammogram	Date:	<input type="checkbox"/> WNL
Last Colonoscopy	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 (or past Hx)	<input type="checkbox"/> Tobacco / Vape Packs/day:
Family History	<input type="checkbox"/> None <input type="checkbox"/> Diabetes	
<input type="checkbox"/> Heart disease	<input type="checkbox"/> HTN	<input type="checkbox"/> Hip fracture
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Cancer	<input type="checkbox"/> Other:

Name:

DOB:

Immunization History / Date	<input type="checkbox"/> None <input type="checkbox"/> See CAIR	<input type="checkbox"/> Tdap:	
<input type="checkbox"/> COVID #1:	<input type="checkbox"/> Influenza:	<input type="checkbox"/> Varicella:	
<input type="checkbox"/> COVID #2:	<input type="checkbox"/> MMR:	<input type="checkbox"/> Zoster:	
<input type="checkbox"/> COVID Booster(s):	<input type="checkbox"/> Hepatitis B:	<input type="checkbox"/> Pneumococcal:	
<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)
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	<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"/>
Hepatitis B	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis C	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
HIV	<input type="checkbox"/> SHA , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Intimate Partner Violence	<input type="checkbox"/> HARK , <input type="checkbox"/> HITS , <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"/>
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"/> H&P, <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"/>	
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"/>
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"/> Influenza vaccine	<input type="checkbox"/> Chlamydia	<input type="checkbox"/> PPD skin test
<input type="checkbox"/> MMR (if not up to date)	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> QFT
<input type="checkbox"/> Pneumococcal (if high risk)	<input type="checkbox"/> HIV	<input type="checkbox"/> CXR
<input type="checkbox"/> Tdap	<input type="checkbox"/> Herpes	<input type="checkbox"/> Urinalysis
<input type="checkbox"/> Varicella (if not up to date)	<input type="checkbox"/> Syphilis	<input type="checkbox"/> ECG
<input type="checkbox"/> Zoster (if high risk)	<input type="checkbox"/> Trichomonas	<input type="checkbox"/> COVID 19 test
<input type="checkbox"/> Other:	<input type="checkbox"/> Rx for folic acid 0.4-0.8mg daily	<input type="checkbox"/> Fasting plasma glucose
	<input type="checkbox"/> gFOBT or Fit	<input type="checkbox"/> Oral glucose tolerance test
	<input type="checkbox"/> Colonoscopy	<input type="checkbox"/> HbA1C
	<input type="checkbox"/> PAP	<input type="checkbox"/> Low to moderate dose statin
	<input type="checkbox"/> Mammogram	<input type="checkbox"/> Bone Density Test
	<input type="checkbox"/> TSH	

Name:

DOB:

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"/> 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 Cessation

Quit Date: _____

<input type="checkbox"/> Advised to quit smoking	<input type="checkbox"/> Discuss smoking cessation medication	<input type="checkbox"/> Discuss 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"/> Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed 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)

Comprehensive Health Assessment

40 to 49 Years: Male	Actual Age:	Date:
Medical Record #		
Primary Language		
Interpreter Requested	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused	
Name of Interpreter		
Intake	Vital Signs	
Allergies	Temp	
Height	BP	
Weight	Pulse	
BMI Value	Resp	
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10	
Dental Provider	Last visit date:	
Advance Directive Info Given/Discussed	<input type="checkbox"/> Yes <input type="checkbox"/> Refused	
Chronic Problems/Significant Conditions: <input type="checkbox"/> See Problem List		
Current Medications/Vitamins: <input type="checkbox"/> See Medication List		
Limitations (physical or mental):		
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)	
Weight <input type="checkbox"/> Loss <input type="checkbox"/> Gain	_____ lbs <input type="checkbox"/> Intentional <input type="checkbox"/> Unintentional	
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
Current Alcohol / Substance Use	<input type="checkbox"/> None	<input type="checkbox"/> Alcohol
<input type="checkbox"/> Drugs (specify):	<input type="checkbox"/> IV Drugs (or past Hx)	<input type="checkbox"/> Tobacco / Vape Packs/day:
Family History	<input type="checkbox"/> Unremarkable	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Heart disease	<input type="checkbox"/> HTN	<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"/> Influenza:	<input type="checkbox"/> Varicella:
<input type="checkbox"/> COVID #2:	<input type="checkbox"/> MMR:	<input type="checkbox"/> Zoster:
<input type="checkbox"/> COVID Booster(s):	<input type="checkbox"/> Pneumococcal:	<input type="checkbox"/> Other:

Name:

DOB:

USPSTF Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/Orders/AG)
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"/>
Colorectal Cancer	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<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"/>
Hepatitis B	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis C	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
HIV	<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"/>
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"/> H&P, <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	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"/>	

Comprehensive Health Assessment

50+ Years: Female	Actual Age:	Date:
Medical Record #		
Primary Language		
Interpreter Requested	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused	
Name of Interpreter		
Intake	Vital Signs	
Allergies	Temp	
Height	BP	
Weight	Pulse	
BMI Value	Resp	
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10	
Dental Provider	Last visit date:	
Advance Directive Info Given/Discussed	<input type="checkbox"/> Yes <input type="checkbox"/> Refused	
Chronic Problems/Significant Conditions: <input type="checkbox"/> See Problem List		
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)		
Limitations (physical or mental):		
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)	
Weight <input type="checkbox"/> Loss <input type="checkbox"/> Gain	_____ lbs	<input type="checkbox"/> Intentional <input type="checkbox"/> Unintentional
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	Date:	<input type="checkbox"/> WNL
Last Mammogram	Date:	<input type="checkbox"/> WNL
Last Colonoscopy	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 (or past Hx)	<input type="checkbox"/> Tobacco / Vape Packs/day:
Family History	<input type="checkbox"/> None <input type="checkbox"/> Diabetes	
<input type="checkbox"/> Heart disease	<input type="checkbox"/> HTN	<input type="checkbox"/> Hip fracture
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Cancer	<input type="checkbox"/> Other:

Name:

DOB:

Immunization History / Date	<input type="checkbox"/> None <input type="checkbox"/> See CAIR	<input type="checkbox"/> Tdap:	
<input type="checkbox"/> COVID #1:	<input type="checkbox"/> Influenza:	<input type="checkbox"/> Varicella:	
<input type="checkbox"/> COVID #2:	<input type="checkbox"/> MMR:	<input type="checkbox"/> Zoster:	
<input type="checkbox"/> COVID Booster(s):	<input type="checkbox"/> Hepatitis B:	<input type="checkbox"/> Pneumococcal:	
<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)
Alcohol Misuse	<input type="checkbox"/> SHA , <input type="checkbox"/> CRAFTT , <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	<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"/> CRAFTT , <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"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis C	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
HIV	<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"/>
Tobacco Use	<input type="checkbox"/> SHA , <input type="checkbox"/> CRAFTT , <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"/> H&P, <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"/>	
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"/>
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"/> Influenza vaccine	<input type="checkbox"/> Chlamydia	<input type="checkbox"/> PPD skin test
<input type="checkbox"/> MMR (if not up to date)	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> QFT
<input type="checkbox"/> Pneumococcal	<input type="checkbox"/> HIV	<input type="checkbox"/> CXR
<input type="checkbox"/> Tdap	<input type="checkbox"/> Herpes	<input type="checkbox"/> Urinalysis
<input type="checkbox"/> Varicella (if not up to date)	<input type="checkbox"/> Syphilis	<input type="checkbox"/> ECG
<input type="checkbox"/> Zoster	<input type="checkbox"/> Trichomonas	<input type="checkbox"/> COVID 19 test
<input type="checkbox"/> Other:	<input type="checkbox"/> Rx for folic acid 0.4-0.8mg daily	<input type="checkbox"/> Fasting plasma glucose
	<input type="checkbox"/> gFOBT or Fit	<input type="checkbox"/> Oral glucose tolerance test
	<input type="checkbox"/> Colonoscopy	<input type="checkbox"/> HbA1C
	<input type="checkbox"/> PAP	<input type="checkbox"/> Low to moderate dose statin
	<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"/> Bone Density Test	

Name: _____ DOB: _____

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 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"/> Safety helmet	<input type="checkbox"/> Aging process
<input type="checkbox"/> Routine dental care	<input type="checkbox"/> ASA use	<input type="checkbox"/> Perimenopause education

Tobacco Cessation Quit Date: _____

<input type="checkbox"/> Advised to quit smoking	<input type="checkbox"/> Discuss smoking cessation medication	<input type="checkbox"/> Discuss 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"/> Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed 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)

Comprehensive Health Assessment

50+ Years: Male	Actual Age: _____	Date: _____
Medical Record #		
Primary Language		
Interpreter Requested	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused	
Name of Interpreter		
Intake	Vital Signs	
Allergies	Temp	
Height	BP	
Weight	Pulse	
BMI Value	Resp	
Pain	Location: _____ Scale: 0 1 2 3 4 5 6 7 8 9 10	
Dental Provider	Last visit date: _____	
Advance Directive Info Given/Discussed	<input type="checkbox"/> Yes <input type="checkbox"/> Refused	
Chronic Problems/Significant Conditions: <input type="checkbox"/> See Problem List		
Current Medications/Vitamins: <input type="checkbox"/> See Medication List		
Limitations (physical or mental): _____		
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)	
Weight <input type="checkbox"/> Loss <input type="checkbox"/> Gain	_____ lbs <input type="checkbox"/> Intentional <input type="checkbox"/> Unintentional	
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
Current Alcohol / Substance Use	<input type="checkbox"/> None <input type="checkbox"/> Alcohol	
<input type="checkbox"/> Drugs (specify): _____	<input type="checkbox"/> IV Drugs (or past Hx)	<input type="checkbox"/> Tobacco / Vape Packs/day: _____
Family History	<input type="checkbox"/> Unremarkable <input type="checkbox"/> Diabetes	
<input type="checkbox"/> Heart disease	<input type="checkbox"/> HTN	<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"/> Tdap: _____ <input type="checkbox"/> See CAIR	
<input type="checkbox"/> COVID #1:	<input type="checkbox"/> Influenza:	<input type="checkbox"/> Varicella:
<input type="checkbox"/> COVID #2:	<input type="checkbox"/> MMR:	<input type="checkbox"/> Zoster:
<input type="checkbox"/> COVID Booster(s):	<input type="checkbox"/> Pneumococcal:	<input type="checkbox"/> Other: _____

Name: _____

DOB: _____

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"/>
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"/>
Colorectal Cancer	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<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"/>
Hepatitis B	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis C	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
HIV	<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"/>
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"/> H&P, <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	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"/>	

Comprehensive Health Assessment

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 <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:

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 Cessation Quit Date:		
<input type="checkbox"/> Advised to quit smoking	<input type="checkbox"/> Discuss smoking cessation medication	<input type="checkbox"/> Discuss smoking cessation strategies
Next Appointment		
<input type="checkbox"/> 1 year	<input type="checkbox"/> RTC PRN	<input type="checkbox"/> Other:

Documentation Reminders		
<input type="checkbox"/> Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed 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)