

Comprehensive Health Assessment Form

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

Name: _____ DOB: _____ MR#: _____

Family History	<input type="checkbox"/> Unremarkable <input type="checkbox"/> Diabetes
<input type="checkbox"/> Heart disease / HTN	<input type="checkbox"/> Lives/lived with someone HBV+ <input type="checkbox"/> Asthma
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Cancer <input type="checkbox"/> Family Hx of unexpected or sudden death < 50 yrs
<input type="checkbox"/> Anemia	<input type="checkbox"/> Other: _____
Psychosocial / Behavioral Social Determinants of Health (SDOH)	<input type="checkbox"/> Unremarkable for social drivers of health <input type="checkbox"/> Changes in family since last visit (move, job, death) <input type="checkbox"/> Problems with housing, food, employment, transportation <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 Education (At each Well Visit)	<input type="checkbox"/> Lead Assessment , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____ <input type="checkbox"/> <input type="checkbox"/>
Dental (cavities, no dental home)	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____ <input type="checkbox"/> <input type="checkbox"/>
Dyslipidemia	<input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____ <input type="checkbox"/> <input type="checkbox"/>
Hepatitis B	<input type="checkbox"/> CDC HEP Risk , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____ <input type="checkbox"/> <input type="checkbox"/>
Member Risk Assessment	<input type="checkbox"/> SDOH , <input type="checkbox"/> PEARLS , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____ <input type="checkbox"/> <input type="checkbox"/>
Psychosocial / Behavioral	<input type="checkbox"/> SDOH , <input type="checkbox"/> PEARLS , <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____ <input type="checkbox"/> <input type="checkbox"/>
Tuberculosis Exposure	<input type="checkbox"/> TB Risk Assessment , <input type="checkbox"/> Other: _____ <input type="checkbox"/> <input type="checkbox"/>
Growth and Development / School Progress Grade: _____	
<input type="checkbox"/> Hops on one foot	<input type="checkbox"/> Counts four pennies <input type="checkbox"/> Copies a square
<input type="checkbox"/> Catches, throws a ball	<input type="checkbox"/> Knows opposites <input type="checkbox"/> Recognizes 3-4 colors
<input type="checkbox"/> Plays with several children	<input type="checkbox"/> Knows name, address, & phone number <input type="checkbox"/> Holds crayon between finger and thumb
Physical Examination WNL	
General appearance	Well-nourished & developed No abuse/neglect evident <input type="checkbox"/>
Head	Symmetrical <input type="checkbox"/>
Eyes	PERLA, 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 / Gums	Pink, no bleeding/inflammation/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"/>

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

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

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

MA / Nurse Signature	Title	Date
Provider Signature	Title	Date

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