

Comprehensive Health Assessment Form

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

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Psychosocial / Behavioral	<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)		
Social Drivers of Health (SDOH)			
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"/>
Developmental Disorder Score: _____	<input type="checkbox"/> ASQ-3 , <input type="checkbox"/> SWYC , <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			
<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 / 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"/>
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"/>

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

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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"/> No bottles
Accident Prevention & Guidance		
<input type="checkbox"/> Lead poisoning prevention	<input type="checkbox"/> Seat belt / Toddler car seat	<input type="checkbox"/> Independence
<input type="checkbox"/> Routine dental care	<input type="checkbox"/> Safety helmet	<input type="checkbox"/> Make-believe / role play
<input type="checkbox"/> Brush teeth with fluoride toothpaste	<input type="checkbox"/> Storage of drugs / toxic chemicals	<input type="checkbox"/> Dressing self
<input type="checkbox"/> Fluoride varnish treatment	<input type="checkbox"/> Matches / burns	<input type="checkbox"/> Reading together / school readiness
<input type="checkbox"/> Family support, social interaction & communication	<input type="checkbox"/> Violence prevention, gun safety	<input type="checkbox"/> Knows name, address, & phone number
<input type="checkbox"/> Caution with strangers	<input type="checkbox"/> Poison control phone number	<input type="checkbox"/> Plays with other children
<input type="checkbox"/> Skin cancer prevention	<input type="checkbox"/> Smoke detector	<input type="checkbox"/> Limit screen time
<input type="checkbox"/> Falls	<input type="checkbox"/> Hot water temp < 120° F	<input type="checkbox"/> Bedtime
<input type="checkbox"/> Effects of passive smoking	<input type="checkbox"/> Drowning / pool fence	<input type="checkbox"/> Toileting habits
Next Appointment		
<input type="checkbox"/> At 3 years old	<input type="checkbox"/> RTC PRN	<input type="checkbox"/> Other:

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

MA / Nurse Signature	Title	Date
Provider Signature	Title	Date

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