

COMPREHENSIVE HEALTH ASSESSMENT FORMS

INDEX

Hold the 'Ctrl' button and then click on any of the links below to access the forms.

[Under 1 Month Old](#)

[1 to 2 Months Old](#)

[3 to 4 Months Old](#)

[5 to 6 Months Old](#)

[7 to 9 Months Old](#) (May use for 10 & 11 Months)

[12 to 15 Months Old](#)

[16 to 23 Months Old](#)

[2 Years Old](#)

[30 Months Old](#)

[3 Years Old](#)

[4 to 5 Years Old](#)

[6 to 8 Years Old](#)

[9 to 12 Years Old](#)

[13 to 16 Years Old](#)

[17 to 20 Years Old](#)

[21 to 39 Years Old - Female](#)

[21 to 39 Years Old - Male](#)

[40 to 49 Years Old - Female](#)

[40 to 49 Years Old - Male](#)

[50+ Years Old - Female](#)

[50+ Years Old - Male](#)

COMPREHENSIVE HEALTH ASSESSMENT FORMS

This page intentionally left blank for printing purposes

Comprehensive Health Assessment Form (√ all that apply)

Under 1 Month 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	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____
Interpreter Requested (if English is not primary language)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused Name of Interpreter: _____
Intake	(See WHO Growth Chart) Vital Signs
Head Circumference	Temp _____
Length	Pulse _____
Weight	Resp _____
Allergies / Reaction	_____
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	
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 Newborn Hearing Screen Results: <input type="checkbox"/> Pass <input type="checkbox"/> Refer	
Cord	<input type="checkbox"/> Absent <input type="checkbox"/> Present <input type="checkbox"/> Redness/swelling <input type="checkbox"/> Yellow drainage
OB/GYN Provider: Post-Partum Appointment Date:	
Chronic Problems/Significant Conditions: <input type="checkbox"/> None <input type="checkbox"/> Born to HBV+ parents <input type="checkbox"/> Other: _____	
Current Medications/Vitamins: <input type="checkbox"/> None	
Interval History (√ all that apply)	
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
WIC Participant	<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 (√ all that apply): <input type="checkbox"/> Unremarkable	
<input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Lives/lived with someone HBV+ <input type="checkbox"/> Cancer <input type="checkbox"/> Heart disease/ HTN <input type="checkbox"/> Childhood hearing impairment <input type="checkbox"/> High cholesterol <input type="checkbox"/> Family Hx of unexpected or sudden death < 50 yrs <input type="checkbox"/> Other: _____	
Social Drivers of Health (SDOH) Psychosocial / Behavioral <input type="checkbox"/> Refused	<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: _____

Name: _____ DOB: _____ MR#: _____

AAP Screening Recommendations	Assessment/ Tools Used	Low Risk	High Risk (see Plan/ Orders/AG)
Hepatitis B <input type="checkbox"/> Refused	<input type="checkbox"/> CDC HEP Risk <input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Maternal Depression Score: _____ <input type="checkbox"/> Refused	<input type="checkbox"/> EPDS <input type="checkbox"/> PHQ-9 <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Member Risk Assessment <input type="checkbox"/> Refused	<input type="checkbox"/> Social Needs <input type="checkbox"/> PEARLS <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Psychosocial / Behavioral <input type="checkbox"/> Refused	<input type="checkbox"/> Social Needs <input type="checkbox"/> PEARLS <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis Exposure <input type="checkbox"/> Refused	<input type="checkbox"/> TB Risk Assessment <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Growth and Development (√ all that apply)			
<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 (√ if WNL)			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 / Gums	Pink, no bleeding/inflammation/lesions 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 Form (√ all that apply)

1 to 2 Months Old	Actual Age: _____ Date: _____
Sex at Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female
Accompanied by	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other: _____
Parent's Primary Language	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____
Interpreter Requested <small>(if English is not primary language)</small>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused Name of Interpreter: _____
Intake	(See WHO Growth Chart) Vital Signs
Head Circumference	Temp _____
Length	Pulse _____
Weight	Resp _____
Allergies / Reaction	
Pain	Location: _____ Scale: 0 1 2 3 4 5 6 7 8 9 10
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	
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	
Newborn Hearing Screen Results <input type="checkbox"/> Pass <input type="checkbox"/> Refer	
OB/GYN Provider:	
Post-Partum Appointment Date:	
Chronic Problems/Significant Conditions: <input type="checkbox"/> None <input type="checkbox"/> Born to HBV+ parents <input type="checkbox"/> Other: _____	
Current Medications/Vitamins: <input type="checkbox"/> None	
Interval History (√ all that apply)	
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
WIC Participant	<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 (√ all that apply): <input type="checkbox"/> Unremarkable	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes <input type="checkbox"/> Lives/lived with someone HBV+
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart disease/ HTN
<input type="checkbox"/> Childhood hearing impairment	<input type="checkbox"/> High cholesterol <input type="checkbox"/> Family Hx of unexpected or sudden death < 50 yrs
<input type="checkbox"/> Other: _____	
Social Drivers of Health (SDOH) 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)
<input type="checkbox"/> Refused	
Lives with	<input type="checkbox"/> 1 Parent <input type="checkbox"/> 2 Parents <input type="checkbox"/> Other: _____

Name: _____ DOB: _____ MR#: _____

AAP Screening Recommendations	Assessment/ Tools Used	Low Risk	High Risk <small>(see Plan/ Orders/AG)</small>
Hepatitis B <input type="checkbox"/> Refused	<input type="checkbox"/> CDC HEP Risk <input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Maternal Depression Score: _____ <input type="checkbox"/> Refused	<input type="checkbox"/> EPDS <input type="checkbox"/> PHQ-9 <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Member Risk Assessment <input type="checkbox"/> Refused	<input type="checkbox"/> Social Needs <input type="checkbox"/> PEARLS <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Psychosocial / Behavioral <input type="checkbox"/> Refused	<input type="checkbox"/> Social Needs <input type="checkbox"/> PEARLS <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis Exposure <input type="checkbox"/> Refused	<input type="checkbox"/> TB Risk Assessment <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Growth and Development (√ all that apply)			
<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 (√ if WNL)			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 / Gums	Pink, no bleeding/inflammation/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 Form (√ all that apply)

3 to 4 Months Old	Actual Age: _____ Date: _____
Sex at Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female
Accompanied by	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other: _____
Parent's Primary Language	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____
Interpreter Requested <small>(if English is not primary language)</small>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused Name of Interpreter: _____
Intake	(See WHO Growth Chart) Vital Signs
Head Circumference	Temp _____
Length	Pulse _____
Weight	Resp _____
Allergies / Reaction	
Pain	Location: _____ Scale: 0 1 2 3 4 5 6 7 8 9 10
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"/> Born to HBV+ parents <input type="checkbox"/> Other: _____	
Current Medications/Vitamins: <input type="checkbox"/> None	
Interval History (√ all that apply)	
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
WIC Participant	<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 (√ all that apply): <input type="checkbox"/> Unremarkable <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Lives/lived with someone HBV+ <input type="checkbox"/> Cancer <input type="checkbox"/> Heart disease/ HTN <input type="checkbox"/> Childhood hearing impairment <input type="checkbox"/> High cholesterol <input type="checkbox"/> Family Hx of unexpected or sudden death < 50 yrs <input type="checkbox"/> Other: _____	
Social Drivers of Health (SDOH) Psychosocial / Behavioral <input type="checkbox"/> Refused	<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: _____

Name: _____ DOB: _____ MR#: _____

AAP Screening Recommendations	Assessment/ Tools Used	Low Risk	High Risk <small>(see Plan/ Orders/AG)</small>
Anemia <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B <input type="checkbox"/> Refused	<input type="checkbox"/> CDC HEP Risk <input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Maternal Depression Score: _____ <input type="checkbox"/> Refused	<input type="checkbox"/> EPDS <input type="checkbox"/> PHQ-9 <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Member Risk Assessment <input type="checkbox"/> Refused	<input type="checkbox"/> Social Needs <input type="checkbox"/> PEARLS <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Psychosocial / Behavioral <input type="checkbox"/> Refused	<input type="checkbox"/> Social Needs <input type="checkbox"/> PEARLS <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis Exposure <input type="checkbox"/> Refused	<input type="checkbox"/> TB Risk Assessment <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Growth and Development (√ all that apply)			
<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 (√ if WNL)			WNL
General appearance	Well-nourished & developed No abuse/neglect evident	<input type="checkbox"/>	
Head	Symmetrical, A.F. open _____ cm	<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"/>	
Mouth / Gums	Pink, no bleeding/inflammation/lesions	<input type="checkbox"/>	
Neck	Supple, no masses, thyroid not enlarged	<input type="checkbox"/>	
Chest	Symmetrical, no masses	<input type="checkbox"/>	
Heart	No organic murmurs, regular rhythm	<input type="checkbox"/>	
Lungs	Clear to auscultation bilaterally	<input type="checkbox"/>	
Abdomen	Soft, no masses, liver & spleen normal	<input type="checkbox"/>	
Genitalia	Grossly normal	<input type="checkbox"/>	
Male	Circ / uncircumcised, testes in scrotum	<input type="checkbox"/>	
Female	No lesions, normal external appearance	<input type="checkbox"/>	
Hips	Good abduction, leg lengths equal	<input type="checkbox"/>	
Femoral pulses	Present and equal	<input type="checkbox"/>	
Extremities	No deformities, full ROM	<input type="checkbox"/>	
Skin	Clear, no significant lesions	<input type="checkbox"/>	
Neurologic	Alert, no gross sensory or motor deficit	<input type="checkbox"/>	

Comprehensive Health Assessment Form (√ all that apply)

5 to 6 Months Old	Actual Age: _____ Date: _____
Sex at Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female
Accompanied by	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other: _____
Parent's Primary Language	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____
Interpreter Requested (if English is not primary language)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused Name of Interpreter: _____
Intake	(See WHO Growth Chart) Vital Signs
Head Circumference	Temp _____
Length	Pulse _____
Weight	Resp _____
Allergies / Reaction	
Pain	Location: _____ Scale: 0 1 2 3 4 5 6 7 8 9 10
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"/> Born to HBV+ parents <input type="checkbox"/> Other: _____	
Current Medications/Vitamins: <input type="checkbox"/> None	
Interval History (√ all that apply)	
Oral/Dental Health	Teeth present: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental visit within past 3 months: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental Provider Name: _____ Drinks fluoridated water or takes supplements: <input type="checkbox"/> Yes <input type="checkbox"/> No Fluoride varnish applied in last 3 months: <input type="checkbox"/> Yes <input type="checkbox"/> No
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
WIC Participant	<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 (√ all that apply): <input type="checkbox"/> Unremarkable <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Lives/lived with someone HBV+ <input type="checkbox"/> Cancer <input type="checkbox"/> Heart disease/ HTN <input type="checkbox"/> Childhood hearing impairment <input type="checkbox"/> High cholesterol <input type="checkbox"/> Family Hx of unexpected or sudden death < 50 yrs <input type="checkbox"/> Other: _____	
Social Drivers of Health (SDOH) Psychosocial / Behavioral <input type="checkbox"/> Refused	<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: _____

Name: _____ DOB: _____ MR#: _____

AAP Screening Recommendations	Assessment/ Tools Used	Low Risk	High Risk (see Plan/ Orders/AG)
Blood Lead Anticipatory Guidance (start at 6 months) <input type="checkbox"/> Refused	<input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B <input type="checkbox"/> Refused	<input type="checkbox"/> CDC HEP Risk <input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Maternal Depression Score: _____ <input type="checkbox"/> Refused	<input type="checkbox"/> EPDS <input type="checkbox"/> PHQ-9 <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Member Risk Assessment <input type="checkbox"/> Refused	<input type="checkbox"/> Social Needs <input type="checkbox"/> PEARLS <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Psychosocial / Behavioral <input type="checkbox"/> Refused	<input type="checkbox"/> Social Needs <input type="checkbox"/> PEARLS <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis Exposure <input type="checkbox"/> Refused	<input type="checkbox"/> TB Risk Assessment <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Growth and Development (√ all that apply)			
<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 (√ all that apply)			WNL
General appearance	Well-nourished & developed No abuse/neglect evident	<input type="checkbox"/>	
Head	Symmetrical, A.F. open _____ cm	<input type="checkbox"/>	
Eyes	PERRLA, conjunctivae & sclerae clear Red reflexes present, No strabismus Appears to see	<input type="checkbox"/>	
Ears	Canals clear, TMs normal Appears to hear	<input type="checkbox"/>	
Nose	Passages clear, MM pink, no lesions	<input type="checkbox"/>	
Teeth	Present, grossly normal, No visible cavities	<input type="checkbox"/>	
Mouth / 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, leg lengths equal	<input type="checkbox"/>	
Femoral pulses	Normal	<input type="checkbox"/>	
Extremities	No deformities, full ROM	<input type="checkbox"/>	
Skin	Clear, no significant lesions	<input type="checkbox"/>	
Neurologic	Alert, no gross sensory or motor deficit	<input type="checkbox"/>	

Comprehensive Health Assessment Form (√ all that apply)

7 to 9 Months Old (May use for 10 & 11 Mos)	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	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____
Interpreter Requested (if English is not primary language)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused Name of Interpreter: _____
Intake	(See WHO Growth Chart) Vital Signs
Head Circumference	Temp _____
Length	Pulse _____
Weight	Resp _____
Allergies / Reaction	
Pain	Location: _____ Scale: 0 1 2 3 4 5 6 7 8 9 10
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"/> Born to HBV+ parents <input type="checkbox"/> Other: _____	
Current Medications/Vitamins: <input type="checkbox"/> None	
Interval History (√ all that apply)	
Oral/Dental Health	Teeth present: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental visit within past 3 months: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental Provider Name: _____ Drinks fluoridated water or takes supplements: <input type="checkbox"/> Yes <input type="checkbox"/> No Fluoride varnish applied in last 3 months: <input type="checkbox"/> Yes <input type="checkbox"/> No
Diet	<input type="checkbox"/> Regular <input type="checkbox"/> Iron-rich foods <input type="checkbox"/> Other: _____
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
WIC Participant	<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 (√ all that apply): <input type="checkbox"/> Unremarkable <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Lives/lived with someone HBV+ <input type="checkbox"/> Cancer <input type="checkbox"/> Heart disease/ HTN <input type="checkbox"/> Family Hx of unexpected or sudden death < 50 yrs <input type="checkbox"/> Childhood hearing impairment <input type="checkbox"/> High cholesterol <input type="checkbox"/> Other: _____	
Social Drivers of Health (SDOH) Psychosocial / Behavioral <input type="checkbox"/> Refused	<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: _____

Name: _____ DOB: _____ MR#: _____

AAP Screening Recommendations	Assessment/ Tools Used	Low Risk	High Risk (see Plan/ Orders/AG)
Blood Lead Anticipatory Guidance (at each well visit) <input type="checkbox"/> Refused	<input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Developmental Disorder (at 9 months) Score: _____ <input type="checkbox"/> Refused	<input type="checkbox"/> ASQ-3 <input type="checkbox"/> SWYC <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B <input type="checkbox"/> Refused	<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"/> Refused	<input type="checkbox"/> Social Needs <input type="checkbox"/> PEARLS <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Psychosocial / Behavioral <input type="checkbox"/> Refused	<input type="checkbox"/> Social Needs <input type="checkbox"/> PEARLS <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis Exposure <input type="checkbox"/> Refused	<input type="checkbox"/> TB Risk Assessment <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Growth and Development (√ all that apply)			
<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 (√ all that apply)			WNL
General appearance	Well-nourished & developed No abuse/neglect evident	<input type="checkbox"/>	
Head	Symmetrical, A.F. open _____ cm	<input type="checkbox"/>	
Eyes	PERRLA, conjunctivae & sclerae clear Red reflexes present, No strabismus Appears to see	<input type="checkbox"/>	
Ears	Canals clear, TMs normal Appears to hear	<input type="checkbox"/>	
Nose	Passages clear, MM pink, no lesions	<input type="checkbox"/>	
Teeth	Present, grossly normal, No visible cavities	<input type="checkbox"/>	
Mouth / 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"/>	
Skin	Clear, no significant lesions	<input type="checkbox"/>	
Neurologic	Alert, no gross sensory or motor deficit	<input type="checkbox"/>	

Comprehensive Health Assessment Form (√ all that apply)

12 to 15 Months Old	Actual Age: _____ Date: _____
Sex at Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female
Accompanied by	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other: _____
Parent's Primary Language	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____
Interpreter Requested (if English is not primary language)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused Name of Interpreter: _____
Intake	(See WHO Growth Chart) Vital Signs
Head Circumference	Temp _____
Length	Pulse _____
Weight	Resp _____
Allergies / Reaction	
Pain	Location: _____ Scale: 0 1 2 3 4 5 6 7 8 9 10
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	
Current Medications/Vitamins: <input type="checkbox"/> None	
Interval History (√ all that apply)	
Oral/Dental Health	Dental visit within past 12 months: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental Provider Name: _____ Drinks fluoridated water or takes supplements: <input type="checkbox"/> Yes <input type="checkbox"/> No Fluoride varnish applied in last 6 months: <input type="checkbox"/> Yes <input type="checkbox"/> No
Diet / Nutrition	<input type="checkbox"/> Regular <input type="checkbox"/> Iron-rich foods <input type="checkbox"/> Other:
Elimination	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
WIC Participant	<input type="checkbox"/> Yes <input type="checkbox"/> No
Physical Activity	<input type="checkbox"/> Inactive (little or none) <input type="checkbox"/> Some (< 30 min/day) <input type="checkbox"/> Active (> 30 min/day)
Sleep	<input type="checkbox"/> Regular <input type="checkbox"/> Sleep regression <input type="checkbox"/> Nighttime fears
Vaccines Up to Date	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> See CAIR
Family History (√ all that apply): <input type="checkbox"/> Unremarkable <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Lives/lived with someone HBV+ <input type="checkbox"/> Cancer <input type="checkbox"/> Heart disease/ HTN <input type="checkbox"/> Childhood hearing impairment <input type="checkbox"/> High cholesterol <input type="checkbox"/> Family Hx of unexpected or sudden death < 50 yrs <input type="checkbox"/> Other:	
Social Drivers of Health (SDOH) 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) <input type="checkbox"/> Refused to answer
Lives with	<input type="checkbox"/> 1 Parent <input type="checkbox"/> 2 Parents <input type="checkbox"/> Other:

Name: _____ DOB: _____ MR#: _____

AAP Screening Recommendations	Assessment/ Tools Used	Low Risk	High Risk (see Plan/ Orders/AG)
Anemia <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> H&P <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Blood Lead Anticipatory Guidance (at each well visit) Test at 12 months old <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <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"/> Refused	<input type="checkbox"/> H&P <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B <input type="checkbox"/> Refused	<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"/> Refused	<input type="checkbox"/> Social Needs <input type="checkbox"/> PEARLS <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Psychosocial / Behavioral <input type="checkbox"/> Refused	<input type="checkbox"/> Social Needs <input type="checkbox"/> PEARLS <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis Exposure <input type="checkbox"/> Refused	<input type="checkbox"/> TB Risk Assessment <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Growth and Development (√ all that apply)			
<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 (√ all that apply)			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 / 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"/>	
Skin	Clear, no significant lesions	<input type="checkbox"/>	
Neurologic	Alert, no gross sensory or motor deficit	<input type="checkbox"/>	

Comprehensive Health Assessment Form (√ all that apply)

16 to 23 Months Old	Actual Age: _____ Date: _____
Sex at Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female
Accompanied by	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other: _____
Parent's Primary Language	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____
Interpreter Requested (if English is not primary language)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused Name of Interpreter: _____
Intake	(See WHO Growth Chart) Vital Signs
Head Circumference	Temp _____
Length	Pulse _____
Weight	Resp _____
Allergies / Reaction	
Pain	Location: _____ Scale: 0 1 2 3 4 5 6 7 8 9 10
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	
Current Medications/Vitamins: <input type="checkbox"/> None	
Interval History (√ all that apply)	
Oral/Dental Health	Dental visit within past 12 months: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental Provider Name: _____ Drinks fluoridated water or takes supplements: <input type="checkbox"/> Yes <input type="checkbox"/> No Fluoride varnish applied in last 6 months: <input type="checkbox"/> Yes <input type="checkbox"/> No
Diet / Nutrition	<input type="checkbox"/> Regular <input type="checkbox"/> Iron-rich foods <input type="checkbox"/> Other:
Elimination	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
WIC Participant	<input type="checkbox"/> Yes <input type="checkbox"/> No
Physical Activity	<input type="checkbox"/> Inactive (little or none) <input type="checkbox"/> Some (< 30 min/day) <input type="checkbox"/> Active (> 30 min/day)
Sleep	<input type="checkbox"/> Regular <input type="checkbox"/> Sleep regression <input type="checkbox"/> Nighttime fears
Vaccines Up to Date	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> See CAIR
Family History (√ all that apply): <input type="checkbox"/> Unremarkable <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Lives/lived with someone HBV+ <input type="checkbox"/> Cancer <input type="checkbox"/> Heart disease/ HTN <input type="checkbox"/> Childhood hearing impairment <input type="checkbox"/> High cholesterol <input type="checkbox"/> Family Hx of unexpected or sudden death < 50 yrs <input type="checkbox"/> Other:	
Social Drivers of Health (SDOH) 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) <input type="checkbox"/> Refused to answer
Lives with	<input type="checkbox"/> 1 Parent <input type="checkbox"/> 2 Parents <input type="checkbox"/> Other:

Name: _____ DOB: _____ MR#: _____

AAP Screening Recommendations	Assessment/ Tools Used	Low Risk	High Risk (see Plan/ Orders/AG)
Anemia <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> H&P <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Autism Disorder (at 18 months) Score: _____ <input type="checkbox"/> Refused	<input type="checkbox"/> SWYC <input type="checkbox"/> M-CHAT <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Blood Lead Anticipatory Guidance (at each well visit) <input type="checkbox"/> Refused	<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"/> Refused	<input type="checkbox"/> H&P <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Developmental Disorder (at 18 months) Score: _____ <input type="checkbox"/> Refused	<input type="checkbox"/> ASQ-3 <input type="checkbox"/> SWYC <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B <input type="checkbox"/> Refused	<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"/> Refused	<input type="checkbox"/> Social Needs <input type="checkbox"/> PEARLS <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Psychosocial / Behavioral <input type="checkbox"/> Refused	<input type="checkbox"/> Social Needs <input type="checkbox"/> PEARLS <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis Exposure <input type="checkbox"/> Refused	<input type="checkbox"/> TB Risk Assessment <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Growth and Development (√ all that apply)			
<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 (√ all that apply)			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 / 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, leg length equal	<input type="checkbox"/>	

Comprehensive Health Assessment Form (✓ all that apply)

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 (✓ all that apply)		
<input type="checkbox"/> WIC	<input type="checkbox"/> Optometrist / Ophthalmologist	<input type="checkbox"/> Audiologist
<input type="checkbox"/> Dentist	<input type="checkbox"/> Dietician	<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 (✓ all that apply)		
<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 mg QD)	<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: _____ MR#: _____

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

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

MA / Nurse Signature	Title	Date
Provider Signature	Title	Date

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

Comprehensive Health Assessment Form (✓ all that apply)

2 Years Old	Actual Age: _____ Date: _____
Sex at Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female
Accompanied by	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other: _____
Parent's Primary Language	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____
Interpreter Requested (if English is not primary language)	<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
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	
Current Medications/Vitamins: <input type="checkbox"/> None	
Interval History (✓ all that apply)	
Oral/Dental Health	Dental visit within past 12 months: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental Provider Name: _____ 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
WIC Participant	<input type="checkbox"/> Yes <input type="checkbox"/> No
Physical Activity	<input type="checkbox"/> Inactive (little or none) <input type="checkbox"/> Some (< 2 ½ hrs/week) <input type="checkbox"/> Active (> 60 min/day)
Sleep Pattern	<input type="checkbox"/> Regular <input type="checkbox"/> Sleep regression <input type="checkbox"/> Nighttime fears
Vaccines Up to Date	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> See CAIR
Family History (✓ all that apply): <input type="checkbox"/> Unremarkable <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Lives/lived with someone HBV+ <input type="checkbox"/> Cancer <input type="checkbox"/> Heart disease/ HTN <input type="checkbox"/> Childhood hearing impairment <input type="checkbox"/> High cholesterol <input type="checkbox"/> Family Hx of unexpected or sudden death < 50 yrs <input type="checkbox"/> Other:	
Social Drivers of Health (SDOH) 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) <input type="checkbox"/> Refused to answer
Lives with	<input type="checkbox"/> 1 Parent <input type="checkbox"/> 2 Parents <input type="checkbox"/> Other:

Name: _____ DOB: _____ MR#: _____

AAP Screening Recommendations	Assessment/ Tools Used	Low Risk	High Risk (see Plan/ Orders/AG)
Anemia <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> H&P <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Autism Disorder Score: _____ <input type="checkbox"/> Refused	<input type="checkbox"/> SWYC <input type="checkbox"/> M-CHAT <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Blood Lead Anticipatory Guidance (at each well visit) Test at 24 months old <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <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"/> Refused	<input type="checkbox"/> H&P <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Developmental Disorder Score: _____ <input type="checkbox"/> Refused	<input type="checkbox"/> ASQ-3 <input type="checkbox"/> SWYC <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Dyslipidemia <input type="checkbox"/> Refused	<input type="checkbox"/> H&P <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B <input type="checkbox"/> Refused	<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"/> Refused	<input type="checkbox"/> Social Needs <input type="checkbox"/> PEARLS <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Psychosocial / Behavioral <input type="checkbox"/> Refused	<input type="checkbox"/> Social Needs <input type="checkbox"/> PEARLS <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis Exposure <input type="checkbox"/> Refused	<input type="checkbox"/> TB Risk Assessment <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Growth and Development (✓ all that apply)			
<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 (✓ all that apply)			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"/>	

Comprehensive Health Assessment Form (√ all that apply)

Female	No lesions, normal external appearance	<input type="checkbox"/>
Hips	Good abduction	<input type="checkbox"/>
Femoral pulses	Normal	<input type="checkbox"/>
Extremities	No deformities, full ROM	<input type="checkbox"/>
Lymph nodes	Not enlarged	<input type="checkbox"/>
Back	No scoliosis	<input type="checkbox"/>
Skin	Clear, no significant lesions	<input type="checkbox"/>
Neurologic	Alert, no gross sensory or motor deficit	<input type="checkbox"/>

Subjective / Objective

Assessment

Plan

Referrals (√ all that apply)

<input type="checkbox"/> WIC	<input type="checkbox"/> Optometrist / Ophthalmologist	<input type="checkbox"/> Audiologist
<input type="checkbox"/> Dentist	<input type="checkbox"/> Dietician	<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 (√ all that apply)

<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 (at 2 yrs old)	<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 mg QD)	<input type="checkbox"/> Urinalysis
<input type="checkbox"/> Other:	<input type="checkbox"/> ECG	<input type="checkbox"/> COVID 19 test
	<input type="checkbox"/> Fluoride varnish application	

Name: _____ DOB: _____ MR#: _____

Anticipatory Guidance (AG) / Education (√ if discussed)
Health education preference: Verbal Visual Multimedia Other:

Diet, Nutrition & Exercise

<input type="checkbox"/> Weight control / obesity	<input type="checkbox"/> Vegetables, fruits	<input type="checkbox"/> Caloric balance
<input type="checkbox"/> Whole grains / iron-rich foods	<input type="checkbox"/> Switch to low-fat milk	<input type="checkbox"/> Limit candy, chips & ice cream
<input type="checkbox"/> Physical activity / exercise	<input type="checkbox"/> Regular balanced meal with snacks	<input type="checkbox"/> No bottles

Accident Prevention & Guidance

<input type="checkbox"/> Lead poisoning prevention	<input type="checkbox"/> Seat belt / Toddler car seat	<input type="checkbox"/> Independence
<input type="checkbox"/> Routine dental care	<input type="checkbox"/> Safety helmet	<input type="checkbox"/> Make-believe / role play
<input type="checkbox"/> Brush teeth with fluoride toothpaste	<input type="checkbox"/> Storage of drugs / toxic chemicals	<input type="checkbox"/> Dressing self
<input type="checkbox"/> Fluoride varnish treatment	<input type="checkbox"/> Matches / burns	<input type="checkbox"/> Reading together
<input type="checkbox"/> Family support, social interaction & communication	<input type="checkbox"/> Violence prevention, gun safety	<input type="checkbox"/> Mindful of daily movements
<input type="checkbox"/> Caution with strangers	<input type="checkbox"/> Poison control phone number	<input type="checkbox"/> Parallel peer play
<input type="checkbox"/> Skin cancer prevention	<input type="checkbox"/> Smoke detector	<input type="checkbox"/> Limit screen time
<input type="checkbox"/> Falls	<input type="checkbox"/> Hot water temp < 120° F	<input type="checkbox"/> Bedtime
<input type="checkbox"/> Effects of passive smoking	<input type="checkbox"/> Drowning / pool fence	<input type="checkbox"/> Toileting habits / training

Next Appointment

<input type="checkbox"/> At 30 months old	<input type="checkbox"/> RTC PRN	<input type="checkbox"/> Other: _____ months _____ weeks _____ days
---	----------------------------------	--

Documentation Reminders

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

MA / Nurse Signature	Title	Date

Provider Signature	Title	Date

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

<input type="checkbox"/> Member/parent refused the following screening/orders:

Comprehensive Health Assessment Form (√ all that apply)

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	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____
Interpreter Requested (if English is not primary language)	<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
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	
Current Medications/Vitamins: <input type="checkbox"/> None	
Interval History (√ all that apply)	
Oral/Dental Health	Dental visit within past 12 months: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental Provider Name: _____ 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
WIC Participant	<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 (√ all that apply): <input type="checkbox"/> Unremarkable <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Lives/lived with someone HBV+ <input type="checkbox"/> Cancer <input type="checkbox"/> Heart disease/ HTN <input type="checkbox"/> Childhood hearing impairment <input type="checkbox"/> High cholesterol <input type="checkbox"/> Family Hx of unexpected or sudden death < 50 yrs <input type="checkbox"/> Other:	
Social Drivers of Health (SDOH) 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) <input type="checkbox"/> Refused to answer
Lives with	<input type="checkbox"/> 1 Parent <input type="checkbox"/> 2 Parents <input type="checkbox"/> Other:

Name: _____ DOB: _____ MR#: _____

AAP Screening Recommendations	Assessment/ Tools Used	Low Risk	High Risk (see Plan/ Orders/AG)
Anemia <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> H&P <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Blood Lead Anticipatory Guidance (at each well visit) Test if no results on file <input type="checkbox"/> Refused	<input type="checkbox"/> Labs 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"/> Refused	<input type="checkbox"/> H&P <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Developmental Disorder Score: _____ <input type="checkbox"/> Refused	<input type="checkbox"/> ASQ-3 <input type="checkbox"/> SWYC <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B <input type="checkbox"/> Refused	<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"/> Refused	<input type="checkbox"/> Social Needs <input type="checkbox"/> PEARLS <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Psychosocial / Behavioral <input type="checkbox"/> Refused	<input type="checkbox"/> Social Needs <input type="checkbox"/> PEARLS <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis Exposure <input type="checkbox"/> Refused	<input type="checkbox"/> TB Risk Assessment <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Growth and Development (√ all that apply)			
<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 (√ all that apply)			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"/>	

Comprehensive Health Assessment Form (√ all that apply)

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 (√ all that apply)		
<input type="checkbox"/> WIC	<input type="checkbox"/> Optometrist / Ophthalmologist	<input type="checkbox"/> Audiologist
<input type="checkbox"/> Dentist	<input type="checkbox"/> Dietician	<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 (√ all that apply)		
<input type="checkbox"/> COVID 19 vaccine	<input type="checkbox"/> MMR	<input type="checkbox"/> CBC / Basic metabolic panel
<input type="checkbox"/> DTaP	<input type="checkbox"/> PPSV	<input type="checkbox"/> Hct / Hgb (if high risk)
<input type="checkbox"/> Hep A vaccine (if not up to date)	<input type="checkbox"/> PPSV (if high risk)	<input type="checkbox"/> Lipid panel (if high risk)
<input type="checkbox"/> Hep B vaccine (if not up to date)	<input type="checkbox"/> Varicella (2 nd Dose)	<input type="checkbox"/> PPD skin test
		<input type="checkbox"/> QFT
<input type="checkbox"/> IPV	<input type="checkbox"/> Blood Lead (if not in chart)	<input type="checkbox"/> CXR
		<input type="checkbox"/> Urinalysis
<input type="checkbox"/> Influenza vaccine	<input type="checkbox"/> Hep B Panel (if high risk)	<input type="checkbox"/> ECG
		<input type="checkbox"/> COVID 19 test
<input type="checkbox"/> Meningococcal (if high risk)	<input type="checkbox"/> Rx Fluoride drops / chewable tabs (0.25 mg QD)	<input type="checkbox"/> Fluoride varnish application
<input type="checkbox"/> Other:		

Name: _____ DOB: _____ MR#: _____

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

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

MA / Nurse Signature	Title	Date
Provider Signature	Title	Date

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

Comprehensive Health Assessment Form (√ all that apply)

3 Years Old	Actual Age: _____ Date: _____
Sex at Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female
Accompanied by	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other: _____
Parent's Primary Language	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____
Interpreter Requested (if English is not primary language)	<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 (if able)	<input type="checkbox"/> Responded at ≤ 20 dB at 500-4000 frequencies in both ears <input type="checkbox"/> Non coop
Vision Screening	OD: _____ OS: _____ <input type="checkbox"/> Non coop
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	
Current Medications/Vitamins: <input type="checkbox"/> None	
Interval History (√ all that apply)	
Oral/Dental Health	Dental visit within past 12 months: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental Provider Name: _____ 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
WIC Participant	<input type="checkbox"/> Yes <input type="checkbox"/> No
Physical Activity	<input type="checkbox"/> Inactive (little or none) <input type="checkbox"/> Some (< 2 ½ hrs/week) <input type="checkbox"/> Active (> 60 min/day)
Sleep Pattern	<input type="checkbox"/> Regular <input type="checkbox"/> Fatigue <input type="checkbox"/> Snoring <input type="checkbox"/> Enuresis
Vaccines Up to Date	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> See CAIR
Family History (√ all that apply): <input type="checkbox"/> Unremarkable	
<input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Lives/lived with someone HBV+ <input type="checkbox"/> Cancer <input type="checkbox"/> Heart disease/ HTN <input type="checkbox"/> Childhood hearing impairment <input type="checkbox"/> High cholesterol <input type="checkbox"/> Family Hx of unexpected or sudden death < 50 yrs <input type="checkbox"/> Other: _____	

Name:

DOB:

MR#:

Social Drivers of Health (SDOH) 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) <input type="checkbox"/> Refused to answer
Lives with	<input type="checkbox"/> 1 Parent <input type="checkbox"/> 2 Parents <input type="checkbox"/> Other:
AAP Screening Recommendations	Assessment/ Tools Used Low Risk High Risk (see Plan/ Orders/AG)
Anemia <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> H&P <input type="checkbox"/> Other: <input type="checkbox"/> <input type="checkbox"/>
Blood Lead Anticipatory Guidance (At each well visit) Test if no results on file <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <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"/> Refused	<input type="checkbox"/> H&P <input type="checkbox"/> Other: <input type="checkbox"/> <input type="checkbox"/>
Hepatitis B <input type="checkbox"/> Refused	<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"/> Refused	<input type="checkbox"/> Social Needs <input type="checkbox"/> PEARLS <input type="checkbox"/> Other: <input type="checkbox"/> <input type="checkbox"/>
Psychosocial / Behavioral <input type="checkbox"/> Refused	<input type="checkbox"/> Social Needs <input type="checkbox"/> PEARLS <input type="checkbox"/> Other: <input type="checkbox"/> <input type="checkbox"/>
Tuberculosis Exposure <input type="checkbox"/> Refused	<input type="checkbox"/> TB Risk Assessment <input type="checkbox"/> Other: <input type="checkbox"/> <input type="checkbox"/>
Growth and Development (√ all that apply)	
<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 (√ all that apply) 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"/>

Comprehensive Health Assessment Form (√ all that apply)

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 (√ all that apply)		
<input type="checkbox"/> WIC	<input type="checkbox"/> Optometrist / Ophthalmologist	<input type="checkbox"/> Audiologist
<input type="checkbox"/> Dentist	<input type="checkbox"/> Dietician	<input type="checkbox"/> Pulmonologist
<input type="checkbox"/> CA Children's Services (CCS)	<input type="checkbox"/> Regional Center	<input type="checkbox"/> Local Education Agency
<input type="checkbox"/> Other:		
Orders (√ all that apply)		
<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/0.50 mg QD)	<input type="checkbox"/> Fluoride varnish application
<input type="checkbox"/> Other:		

Name: _____ DOB: _____ MR#: _____

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

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

MA / Nurse Signature	Title	Date
Provider Signature	Title	Date

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

Comprehensive Health Assessment Form (√ all that apply)

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	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____
Interpreter Requested (if English is not primary language)	<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 ≤ 20 dB at 500-4000 frequencies in both ears <input type="checkbox"/> Non coop
Vision Screening	OD: _____ OS: _____ <input type="checkbox"/> Non coop
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: (√ all that apply) <input type="checkbox"/> None <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Obesity <input type="checkbox"/> Seizures <input type="checkbox"/> Other: _____	
Current Medications/Vitamins: <input type="checkbox"/> None <input type="checkbox"/> See Medication List	
Interval History (√ all that apply)	
Oral/Dental Health	Dental visit within past 12 months: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental Provider Name: _____ 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
WIC Participant	<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
Family History (√ all that apply): <input type="checkbox"/> Unremarkable <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Lives/lived with someone HBV+ <input type="checkbox"/> Cancer <input type="checkbox"/> Heart disease/ HTN <input type="checkbox"/> Childhood hearing impairment <input type="checkbox"/> High cholesterol <input type="checkbox"/> Family Hx of unexpected or sudden death < 50 yrs <input type="checkbox"/> Other: _____	

Name: _____

DOB: _____

MR#: _____

Social Drivers of Health (SDOH) 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) <input type="checkbox"/> Refused to answer
Lives with	<input type="checkbox"/> 1 Parent <input type="checkbox"/> 2 Parents <input type="checkbox"/> Other: _____
AAP Screening Recommendations	Assessment/ Tools Used Low Risk High Risk (see Plan/ Orders/AG)
Anemia <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> H&P <input type="checkbox"/> Other: _____ <input type="checkbox"/> <input type="checkbox"/>
Blood Lead Anticipatory Guidance (At each well visit) Test if no results on file <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <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"/> Refused	<input type="checkbox"/> H&P <input type="checkbox"/> Other: _____ <input type="checkbox"/> <input type="checkbox"/>
Dyslipidemia <input type="checkbox"/> Refused	<input type="checkbox"/> H&P <input type="checkbox"/> Other: _____ <input type="checkbox"/> <input type="checkbox"/>
Hepatitis B <input type="checkbox"/> Refused	<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"/> Refused	<input type="checkbox"/> Social Needs <input type="checkbox"/> PEARLS <input type="checkbox"/> Other: _____ <input type="checkbox"/> <input type="checkbox"/>
Psychosocial / Behavioral <input type="checkbox"/> Refused	<input type="checkbox"/> Social Needs <input type="checkbox"/> PEARLS <input type="checkbox"/> Other: _____ <input type="checkbox"/> <input type="checkbox"/>
Tuberculosis Exposure <input type="checkbox"/> Refused	<input type="checkbox"/> TB Risk Assessment <input type="checkbox"/> Other: _____ <input type="checkbox"/> <input type="checkbox"/>
Growth and Development / School Progress (√ all that apply) 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 (√ all that apply) 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 / 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"/>

Comprehensive Health Assessment Form (✓ all that apply)

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 (✓ all that apply)		
<input type="checkbox"/> WIC	<input type="checkbox"/> Optometrist / Ophthalmologist	<input type="checkbox"/> Audiologist
<input type="checkbox"/> Dentist	<input type="checkbox"/> Dietician	<input type="checkbox"/> Pulmonologist
<input type="checkbox"/> CA Children's Services (CCS)	<input type="checkbox"/> Regional Center	<input type="checkbox"/> 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 mg/0.50 mg QD)	<input type="checkbox"/> Urinalysis at 5 years
<input type="checkbox"/> ECG	<input type="checkbox"/> COVID 19 test	<input type="checkbox"/> Fluoride varnish application
<input type="checkbox"/> Other:		

Name: _____ DOB: _____ MR#: _____

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

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

MA / Nurse Signature	Title	Date
Provider Signature	Title	Date

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

Comprehensive Health Assessment Form (√ all that apply)

6 to 8 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	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____
Interpreter Requested (if English is not primary language)	<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 ≤ 20 dB at 500-4000 frequencies in both ears <input type="checkbox"/> Non coop
Vision Screening	OD: _____ OS: _____ <input type="checkbox"/> Non coop
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: (√ all that apply) <input type="checkbox"/> None <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Obesity <input type="checkbox"/> Seizures <input type="checkbox"/> Other: _____	
Current Medications/Vitamins: <input type="checkbox"/> None <input type="checkbox"/> See Medication List	
Interval History (√ all that apply)	
Oral/Dental Health	Dental visit within past 12 months: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental Provider Name: _____ Drinks fluoridated water or takes supplements: <input type="checkbox"/> Yes <input type="checkbox"/> No
Diet / Nutrition	<input type="checkbox"/> Regular <input type="checkbox"/> Iron-rich foods <input type="checkbox"/> Other: _____
Appetite	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
Physical Activity	<input type="checkbox"/> Inactive (little or none) <input type="checkbox"/> Some (< 2 ½ hrs/week) <input type="checkbox"/> Active (≥ 60 min/day) <input type="checkbox"/> Fainting <input type="checkbox"/> Sudden seizures <input type="checkbox"/> SOB <input type="checkbox"/> Chest pain
Sleep Pattern	<input type="checkbox"/> Regular <input type="checkbox"/> Fatigue <input type="checkbox"/> Snoring <input type="checkbox"/> Enuresis
Vaccines Up to Date	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> See CAIR
Family History (√ all that apply): <input type="checkbox"/> Unremarkable <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Lives/lived with someone HBV+ <input type="checkbox"/> Cancer <input type="checkbox"/> Heart disease/ HTN <input type="checkbox"/> Childhood hearing impairment <input type="checkbox"/> High cholesterol <input type="checkbox"/> Family Hx of unexpected or sudden death < 50 yrs <input type="checkbox"/> Other: _____	
Social Drivers of Health (SDOH) 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) <input type="checkbox"/> Refused to answer
Lives with	<input type="checkbox"/> 1 Parent <input type="checkbox"/> 2 Parents <input type="checkbox"/> Other: _____

Name: _____ DOB: _____ MR#: _____

AAP Screening Recommendations	Assessment/ Tools Used	Low Risk	High Risk (see Plan/ Orders/AG)
Anemia <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Dental (cavities, no dental home) <input type="checkbox"/> Refused	<input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Dyslipidemia <input type="checkbox"/> Refused	<input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B <input type="checkbox"/> Refused	<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"/> Refused	<input type="checkbox"/> Social Needs <input type="checkbox"/> PEARLS <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Psychosocial / Behavioral <input type="checkbox"/> Refused	<input type="checkbox"/> Social Needs <input type="checkbox"/> PEARLS <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis Exposure <input type="checkbox"/> Refused	<input type="checkbox"/> TB Risk Assessment <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Growth and Development / School Progress (√ all that apply)			
Grade: _____			
<input type="checkbox"/> Rides bicycle	<input type="checkbox"/> Knows right from left	<input type="checkbox"/> Reads for pleasure	
<input type="checkbox"/> Ties shoelaces	<input type="checkbox"/> Draws person with 6 parts including clothing	<input type="checkbox"/> Tells time	
<input type="checkbox"/> Rules and consequences	<input type="checkbox"/> Independence	<input type="checkbox"/> Prints first name	
Physical Examination (√ all that apply)			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 / Gums	Pink, no bleeding/inflammation/lesions	<input type="checkbox"/>	
Chest / Breast	Symmetrical, no masses	<input type="checkbox"/>	
Heart	No organic murmurs, regular rhythm	<input type="checkbox"/>	
Lungs	Clear to auscultation bilaterally	<input type="checkbox"/>	
Abdomen	Soft, no masses, liver & spleen normal	<input type="checkbox"/>	
Genitalia	Grossly normal	<input type="checkbox"/>	
Male	Circ / uncircumcised, testes in scrotum	<input type="checkbox"/>	
Female	No lesions, normal external appearance	<input type="checkbox"/>	
Femoral pulses	Normal	<input type="checkbox"/>	
Extremities	No deformities, full ROM	<input type="checkbox"/>	
Lymph nodes	Not enlarged	<input type="checkbox"/>	
Back	No scoliosis	<input type="checkbox"/>	
Skin	Clear, no significant lesions	<input type="checkbox"/>	
Neurologic	Alert, no gross sensory or motor deficit	<input type="checkbox"/>	

Comprehensive Health Assessment Form (√ all that apply)

9 to 12 Years Old	Actual Age: _____ Date: _____
Sex at Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female
Accompanied By	<input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Other: _____
Primary Language	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____
Interpreter Requested (if English is not primary language)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused Name of Interpreter: _____
Intake	(See CDC Growth Chart) Vital Signs
Height	Temp _____
Weight	BP _____
BMI Value	Pulse _____
BMI %	Resp _____
Allergies / Reaction	
Pain	Location: _____ Scale: 0 1 2 3 4 5 6 7 8 9 10
Hearing Screening	<input type="checkbox"/> 9-10 Yrs Old: Responded at ≤ 20 dB at 500-4000 frequencies in both ears <input type="checkbox"/> Non coop <input type="checkbox"/> ≥11 Yrs Old: Responded at ≤ 20 dB at 500-8000 frequencies in both ears
Vision Screening	OD: _____ OS: _____ <input type="checkbox"/> Non coop
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: (√ all that apply) <input type="checkbox"/> None	<input type="checkbox"/> Asthma <input type="checkbox"/> Depression <input type="checkbox"/> Diabetes <input type="checkbox"/> Obesity <input type="checkbox"/> Seizures <input type="checkbox"/> Other: _____
Current Medications/Vitamins: <input type="checkbox"/> None <input type="checkbox"/> See Medication List	
Interval History (√ all that apply)	
Oral/Dental Health	Dental visit within past 12 months: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental Provider Name: _____ Drinks fluoridated water or takes supplements: <input type="checkbox"/> Yes <input type="checkbox"/> No
Diet / Nutrition	<input type="checkbox"/> Regular <input type="checkbox"/> Low calorie <input type="checkbox"/> ADA <input type="checkbox"/> Iron-rich foods <input type="checkbox"/> Other: _____
Appetite	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
Physical Activity	<input type="checkbox"/> Inactive (little or none) <input type="checkbox"/> Some (< 2 ½ hrs/week) <input type="checkbox"/> Active (≥ 60 min/day) <input type="checkbox"/> Fainting <input type="checkbox"/> Sudden seizures <input type="checkbox"/> SOB <input type="checkbox"/> Chest pain
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
Sexual Activity (past 12 months) <input type="checkbox"/> Never had sex	<input type="checkbox"/> Currently sexually active <input type="checkbox"/> Not sexually active Current/Past Hx/Risk (√ all that apply): <input type="checkbox"/> Vaginal <input type="checkbox"/> Oral <input type="checkbox"/> Rectal <input type="checkbox"/> Single Partner <input type="checkbox"/> Multiple Partners <input type="checkbox"/> IV Drug use <input type="checkbox"/> STI <input type="checkbox"/> Men having sex with men
Contraception Method: <input type="checkbox"/> None <input type="checkbox"/> Condoms <input type="checkbox"/> Other: _____	
LMP (females): ____/____/____	<input type="checkbox"/> Pregnant: EDD ____/____/____ <input type="checkbox"/> Menorrhagia
Alcohol Use (past 12 months) <input type="checkbox"/> Never Used Alcohol	<input type="checkbox"/> Current Drinker (assess further with CRAFFT) <input type="checkbox"/> Former Drinker (assess further with CRAFFT)
Drug Use (past 12 months) <input type="checkbox"/> Never Used Drugs	<input type="checkbox"/> Current User (assess further with CRAFFT) <input type="checkbox"/> Former User (assess further with CRAFFT) Type used (√ all that apply): <input type="checkbox"/> marijuana <input type="checkbox"/> cocaine <input type="checkbox"/> heroin <input type="checkbox"/> methamphetamine <input type="checkbox"/> prescription meds <input type="checkbox"/> other: _____

Name: _____ DOB: _____ MR#: _____

Tobacco Use / Cessation <input type="checkbox"/> Never smoked or used tobacco products			
<input type="checkbox"/> Current smoker/tobacco user: # Yrs smoked _____ # Cigarettes smoked/day _____			
<input type="checkbox"/> Former smoker/tobacco user: # Yrs smoked _____ # Cigarettes smoked/day _____ Quit date _____			
Type used: <input type="checkbox"/> Cigarettes <input type="checkbox"/> Chewing tobacco <input type="checkbox"/> Vaping products <input type="checkbox"/> Other: _____			
Family History (√ all that apply): <input type="checkbox"/> Unremarkable			
<input type="checkbox"/> Asthma <input type="checkbox"/> Heart disease/ HTN <input type="checkbox"/> Family Hx of unexpected or sudden death < 50 yrs			
<input type="checkbox"/> Cancer <input type="checkbox"/> High cholesterol			
<input type="checkbox"/> Diabetes <input type="checkbox"/> Other: _____			
Social Drivers of Health (SDOH) Psychosocial / Behavioral <input type="checkbox"/> Refused	<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 Screening Recommendations	Assessment/ Tools Used	Low Risk	High Risk (see Plan/ Orders/AG)
Alcohol Misuse Score: _____ (start at 11 yrs old) <input type="checkbox"/> Refused	<input type="checkbox"/> CRAFFT <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Anemia <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Dental (cavities, no dental home) <input type="checkbox"/> Refused	<input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Depression Score: _____ (start at 12 yrs old) <input type="checkbox"/> Refused	<input type="checkbox"/> PHQ-9A <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Drug Misuse Score: _____ (start at 11 years old) <input type="checkbox"/> Refused	<input type="checkbox"/> CRAFFT <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Dyslipidemia (Asses risk at each well visit) Lipid Panel once between 9-11 years old <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B <input type="checkbox"/> Refused	<input type="checkbox"/> CDC HEP Risk <input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
HIV (start at 11 yrs old) <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Member Risk Assessment <input type="checkbox"/> Refused	<input type="checkbox"/> PEARLS <input type="checkbox"/> PEARLS-12&UP <input type="checkbox"/> Social Needs <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Psychosocial / Behavioral <input type="checkbox"/> Refused	<input type="checkbox"/> PEARLS <input type="checkbox"/> PEARLS-12&UP <input type="checkbox"/> Social Needs <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Sexually Transmitted Infections (start at 11 yrs old) <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> SHA <input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Sudden Cardiac Arrest (start at 11 yrs old) <input type="checkbox"/> Refused	<input type="checkbox"/> SCD <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Suicide (start at 12 yrs old) <input type="checkbox"/> Refused	<input type="checkbox"/> ASQ <input type="checkbox"/> PHQ-9A <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco Use <input type="checkbox"/> Refused	<input type="checkbox"/> CRAFFT <input type="checkbox"/> H&P, <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis Exposure <input type="checkbox"/> Refused	<input type="checkbox"/> TB Risk Assessment <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

Comprehensive Health Assessment Form (√ all that apply)

Growth and Development / School Progress (√ all that apply)		
Grade: _____		
<input type="checkbox"/> School achievement	<input type="checkbox"/> Performs chores	<input type="checkbox"/> Plays / listens to music
<input type="checkbox"/> Regular school attendance	<input type="checkbox"/> Exhibit compassion & empathy	<input type="checkbox"/> Reads for pleasure
<input type="checkbox"/> Caring & supportive relationships with family & peers	<input type="checkbox"/> Participates in organized sports / social activities	<input type="checkbox"/> Demonstrate social & emotional competence (including self-regulation)

Physical Examination (√ all that apply)		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 / Gums	Pink, no bleeding/inflammation/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 (√ all that apply)		
<input type="checkbox"/> Dentist	<input type="checkbox"/> Optometrist / Ophthalmologist	<input type="checkbox"/> Dietician
<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"/> Local Education Agency
<input type="checkbox"/> Eating disorder Tx	<input type="checkbox"/> Other: _____	

Name: _____ DOB: _____ MR#: _____

Orders (√ all that apply)		
<input type="checkbox"/> COVID 19 vaccine	<input type="checkbox"/> Hep B Panel	<input type="checkbox"/> CBC/Basic metabolic panel
<input type="checkbox"/> Hep B vaccine (if not given previously)	<input type="checkbox"/> Chlamydia <input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Hct / Hgb (yearly if menstruating)
<input type="checkbox"/> HPV vaccine	<input type="checkbox"/> HIV (if high risk)	<input type="checkbox"/> Lipid panel (once between 9-11 yrs)
<input type="checkbox"/> Influenza vaccine	<input type="checkbox"/> HIV PrEP	<input type="checkbox"/> PPD skin test
<input type="checkbox"/> Meningococcal vaccine (11 to 12 yrs)	<input type="checkbox"/> Herpes <input type="checkbox"/> Syphilis	<input type="checkbox"/> QFT
<input type="checkbox"/> MMR (if not up to date)	<input type="checkbox"/> Trichomonas	<input type="checkbox"/> CXR
<input type="checkbox"/> Tdap	<input type="checkbox"/> TSH	<input type="checkbox"/> Urinalysis
<input type="checkbox"/> Varicella (if not up to date)	<input type="checkbox"/> Rx Fluoride drops / chewable tabs (0.50 mg/1.0 mg QD)	<input type="checkbox"/> ECG <input type="checkbox"/> COVID 19 test
<input type="checkbox"/> Other: _____		

Anticipatory Guidance (AG) / Education (√ if discussed)
Health education preference: Verbal Visual Multimedia Other: _____

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

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"/> Early Sex education / Safe sex practices	<input type="checkbox"/> Non-violent conflict resolution	<input type="checkbox"/> Physical growth
<input type="checkbox"/> Skin cancer prevention	<input type="checkbox"/> Safety helmet	<input type="checkbox"/> Routine dental care
<input type="checkbox"/> Smoking/vaping prevention/ cessation	<input type="checkbox"/> Seat belt	<input type="checkbox"/> Puberty

Next Appointment		
<input type="checkbox"/> 1 year	<input type="checkbox"/> RTC PRN	<input type="checkbox"/> Other: _____ months _____ weeks _____ days

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

MA / Nurse Signature	Title	Date
Provider Signature	Title	Date

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

Comprehensive Health Assessment Form (√ all that apply)

13 to 16 Years Old	Actual Age: _____ Date: _____
Sex at Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female
Accompanied By	<input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Other: _____
Primary Language	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____
Interpreter Requested (if English is not primary language)	<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 ≤ 20 dB at 500-8000 frequencies in both ears <input type="checkbox"/> Non coop
Vision Screening	OD: _____ OS: _____ <input type="checkbox"/> Non coop
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: (√ all that apply) <input type="checkbox"/> None	<input type="checkbox"/> Asthma <input type="checkbox"/> Depression <input type="checkbox"/> Diabetes <input type="checkbox"/> Obesity <input type="checkbox"/> Seizures <input type="checkbox"/> Other: _____
Current Medications/Vitamins: <input type="checkbox"/> None <input type="checkbox"/> See Medication List	
Interval History (√ all that apply)	
Oral/Dental Health	Dental visit within past 12 months: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental Provider Name: _____ Drinks fluoridated water or takes supplements: <input type="checkbox"/> Yes <input type="checkbox"/> No
Diet / Nutrition	<input type="checkbox"/> Regular <input type="checkbox"/> Low calorie <input type="checkbox"/> ADA <input type="checkbox"/> Iron-rich foods <input type="checkbox"/> Other: _____
Appetite	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
Physical Activity	<input type="checkbox"/> Inactive (little or none) <input type="checkbox"/> Some (< 2 ½ hrs/week) <input type="checkbox"/> Active (≥ 60 min/day) <input type="checkbox"/> Fainting <input type="checkbox"/> Sudden seizures <input type="checkbox"/> SOB <input type="checkbox"/> Chest pain
Vaccines Up to Date	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> See CAIR
Sexual Activity (past 12 months) <input type="checkbox"/> Never had sex	<input type="checkbox"/> Currently sexually active <input type="checkbox"/> Not sexually active Current/Past Hx/Risk (√ all that apply): <input type="checkbox"/> Vaginal <input type="checkbox"/> Oral <input type="checkbox"/> Rectal <input type="checkbox"/> Single Partner <input type="checkbox"/> Multiple Partners <input type="checkbox"/> IV Drug use <input type="checkbox"/> STI <input type="checkbox"/> Men having sex with men
Contraception Method: <input type="checkbox"/> None <input type="checkbox"/> Condoms <input type="checkbox"/> Other: _____	
LMP (females): ____/____/____	<input type="checkbox"/> Pregnant: EDD ____/____/____ <input type="checkbox"/> Menorrhagia
Alcohol Use (past 12 months) <input type="checkbox"/> Never Used Alcohol	<input type="checkbox"/> Current Drinker (assess further with CRAFFT) <input type="checkbox"/> Former Drinker (assess further with CRAFFT)
Drug Use (past 12 months) <input type="checkbox"/> Never Used Drugs	<input type="checkbox"/> Current User (assess further with CRAFFT) <input type="checkbox"/> Former User (assess further with CRAFFT) Type used (√ all that apply): <input type="checkbox"/> marijuana <input type="checkbox"/> cocaine <input type="checkbox"/> heroin <input type="checkbox"/> methamphetamine <input type="checkbox"/> prescription meds <input type="checkbox"/> other: _____

Name: _____ DOB: _____ MR#: _____

Tobacco Use / Cessation <input type="checkbox"/> Never smoked or used tobacco products			
<input type="checkbox"/> Current smoker/tobacco user: # Yrs smoked _____ # Cigarettes smoked/day _____			
<input type="checkbox"/> Former smoker/tobacco user: # Yrs smoked _____ # Cigarettes smoked/day _____ Quit date _____			
Type used: <input type="checkbox"/> Cigarettes <input type="checkbox"/> Chewing tobacco <input type="checkbox"/> Vaping products <input type="checkbox"/> Other: _____			
Family History (√ all that apply): <input type="checkbox"/> Unremarkable			
<input type="checkbox"/> Asthma <input type="checkbox"/> Heart disease/ HTN <input type="checkbox"/> Family Hx of unexpected or sudden death < 50yrs			
<input type="checkbox"/> Cancer <input type="checkbox"/> High cholesterol			
<input type="checkbox"/> Diabetes			
<input type="checkbox"/> Other: _____			
Social Drivers of Health (SDOH) 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) <input type="checkbox"/> Refused to answer	
Lives with		<input type="checkbox"/> 1 Parent <input type="checkbox"/> 2 Parents <input type="checkbox"/> Other: _____	
AAP Screening Recommendations	Assessment/ Tools Used	Low Risk	High Risk (see Plan/ Orders/AG)
Alcohol Misuse Score: _____ <input type="checkbox"/> Refused	<input type="checkbox"/> CRAFFT <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Anemia <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Dental (cavities, no dental home) <input type="checkbox"/> Refused	<input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Depression Score: _____ <input type="checkbox"/> Refused	<input type="checkbox"/> PHQ-9A <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Drug Misuse Score: _____ <input type="checkbox"/> Refused	<input type="checkbox"/> CRAFFT <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Dyslipidemia <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B <input type="checkbox"/> Refused	<input type="checkbox"/> CDC HEP Risk <input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
HIV (Asses risk at each well visit) Test at least once starting at 15 yrs old <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Member Risk Assessment <input type="checkbox"/> Refused	<input type="checkbox"/> Social Needs <input type="checkbox"/> PEARLS <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Psychosocial / Behavioral <input type="checkbox"/> Refused	<input type="checkbox"/> Social Needs , <input type="checkbox"/> PEARLS , <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Sexually Transmitted Infections <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <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"/> Refused	<input type="checkbox"/> SCD <input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Suicide <input type="checkbox"/> Refused	<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"/> Refused	<input type="checkbox"/> CRAFFT <input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis Exposure <input type="checkbox"/> Refused	<input type="checkbox"/> TB Risk Assessment <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Growth and Development / School Progress (√ all that apply)			
Grade: _____			
<input type="checkbox"/> School achievement	<input type="checkbox"/> Performs chores	<input type="checkbox"/> Plays / listens to music	
<input type="checkbox"/> Regular 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"/> Ability to get along with peers	

Comprehensive Health Assessment Form (✓ all that apply)

Physical Examination (✓ all that apply)		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 / Gums	Pink, no bleeding/inflammation/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 (✓ all that apply)		
<input type="checkbox"/> Dentist	<input type="checkbox"/> Optometrist / Ophthalmologist	<input type="checkbox"/> Dietician
<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"/> Local Education Agency
<input type="checkbox"/> Eating disorder Tx	<input type="checkbox"/> Other:	
Orders (✓ all that apply)		
<input type="checkbox"/> COVID 19 vaccine	<input type="checkbox"/> Hep B Panel	<input type="checkbox"/> CBC/Basic metabolic panel

Name: _____ DOB: _____ MR#: _____

<input type="checkbox"/> Hep B vaccine (if not up to date)	<input type="checkbox"/> Chlamydia <input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Hct / Hgb (yearly if menstruating)
<input type="checkbox"/> HPV vaccine	<input type="checkbox"/> HIV (if high risk)	<input type="checkbox"/> Lipid panel (if high risk)
<input type="checkbox"/> Influenza vaccine	<input type="checkbox"/> HIV PrEP	<input type="checkbox"/> Glucose
<input type="checkbox"/> Meningococcal vaccine (if not up to date)	<input type="checkbox"/> Herpes <input type="checkbox"/> Syphilis	<input type="checkbox"/> PPD skin test <input type="checkbox"/> QFT
<input type="checkbox"/> MMR (if not up to date)	<input type="checkbox"/> Trichomonas	<input type="checkbox"/> CXR
<input type="checkbox"/> Tdap	<input type="checkbox"/> TSH	<input type="checkbox"/> Urinalysis
<input type="checkbox"/> Varicella (if not up to date)	<input type="checkbox"/> Rx Fluoride drops / chewable tabs (0.50 mg/1.0 mg QD)	<input type="checkbox"/> ECG <input type="checkbox"/> COVID 19 test
<input type="checkbox"/> Other:		
Anticipatory Guidance (AG) / Education (✓ if discussed)		
Health education preference: <input type="checkbox"/> Verbal <input type="checkbox"/> Visual <input type="checkbox"/> Multimedia <input type="checkbox"/> Other:		
Diet, Nutrition & Exercise		
<input type="checkbox"/> Physical activity / exercise	<input type="checkbox"/> Whole grains / iron-rich foods	<input type="checkbox"/> Lean protein
<input type="checkbox"/> Weight control / obesity	<input type="checkbox"/> Vegetables, fruits	<input type="checkbox"/> Limit fatty, sugary & salty foods
<input type="checkbox"/> Eating disorder	<input type="checkbox"/> Healthy food choices	<input type="checkbox"/> Limit candy, chips & ice cream
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"/> Motor vehicle safety (seat belts, no texting & driving)	<input type="checkbox"/> Family support, social interaction & communication
<input type="checkbox"/> Safe sex practices (condoms, contraception, HIV/AIDS)	<input type="checkbox"/> Smoking/vaping prevention/cessation	<input type="checkbox"/> Sexuality
<input type="checkbox"/> Skin cancer prevention	<input type="checkbox"/> Routine dental care	<input type="checkbox"/> Physical growth
Next Appointment		
<input type="checkbox"/> 1 year	<input type="checkbox"/> RTC PRN	<input type="checkbox"/> Other: _____ months _____ weeks _____ days

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

MA / Nurse Signature	Title	Date
Provider Signature	Title	Date

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

Comprehensive Health Assessment Form (√ all that apply)

17 to 20 Years	Actual Age: _____ Date: _____
Sex at Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female
Accompanied By	<input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Other: _____
Primary Language	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____
Interpreter Requested (if English is not primary language)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused Name of Interpreter: _____
Intake	(See CDC Growth Chart) Vital Signs
Height	Temp
Weight <input type="checkbox"/> Significant loss/gain: ___lbs	BP
BMI Value	Pulse
BMI %	Resp
Allergies / Reaction	
Pain	Location: _____ Scale: 0 1 2 3 4 5 6 7 8 9 10
Hearing Screening	<input type="checkbox"/> Responded at ≤ 20 dB at 500-8000 frequencies in both ears <input type="checkbox"/> Non coop
Vision Screening	OD: _____ OS: _____ <input type="checkbox"/> Non coop
Country of Birth: <input type="checkbox"/> US <input type="checkbox"/> Other: _____	
Advance Health Care Directive (Adults 18 yrs old+ and emancipated minors) AHCD information offered/discussed (review at least every 5 years): <input type="checkbox"/> Yes <input type="checkbox"/> Refused AHCD information <input type="checkbox"/> Has Advanced Directive-requested copy	
Chronic Problems/Significant Conditions: (√ all that apply) <input type="checkbox"/> None <input type="checkbox"/> Asthma <input type="checkbox"/> Depression <input type="checkbox"/> Diabetes <input type="checkbox"/> Obesity <input type="checkbox"/> Seizures <input type="checkbox"/> Other: _____	
Current Medications/Vitamins: <input type="checkbox"/> None <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 (√ all that apply)	
Oral/Dental Health	Dental visit within past 12 months: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental Provider Name: _____
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
Sexual Activity (past 12 months) <input type="checkbox"/> Never had sex <input type="checkbox"/> Currently sexually active <input type="checkbox"/> Not sexually active Current/Past Hx/Risk (√ all that apply): <input type="checkbox"/> Vaginal <input type="checkbox"/> Oral <input type="checkbox"/> Rectal <input type="checkbox"/> Single Partner <input type="checkbox"/> Multiple Partners <input type="checkbox"/> IV Drug use <input type="checkbox"/> STI <input type="checkbox"/> Men having sex with men	
Contraception Method: <input type="checkbox"/> None <input type="checkbox"/> Condoms <input type="checkbox"/> Other: Planning to conceive within next year: <input type="checkbox"/> Yes <input type="checkbox"/> No	
LMP (females): ____/____/____	G: ____ P: ____ A: ____ <input type="checkbox"/> Pregnant: EDD ____/____/____ <input type="checkbox"/> Menorrhagia
Alcohol Use (past 12 months) <input type="checkbox"/> Never Used Alcohol <input type="checkbox"/> Current Drinker (assess further with CRAFFT) <input type="checkbox"/> Former Drinker (assess further with CRAFFT)	
Drug Use (past 12 months) <input type="checkbox"/> Never Used Drugs <input type="checkbox"/> Current User (assess further with CRAFFT) <input type="checkbox"/> Former User (assess further with CRAFFT) Type used (√ all that apply): <input type="checkbox"/> marijuana <input type="checkbox"/> cocaine <input type="checkbox"/> heroin <input type="checkbox"/> methamphetamine <input type="checkbox"/> prescription meds <input type="checkbox"/> other: _____	

Name: _____ DOB: _____ MR#: _____

Tobacco Use / Cessation <input type="checkbox"/> Never smoked or used tobacco products <input type="checkbox"/> Current smoker/tobacco user: # Yrs smoked _____ # Cigarettes smoked/day _____ <input type="checkbox"/> Former smoker/tobacco user: # Yrs smoked _____ # Cigarettes smoked/day _____ Quit date _____ Type used: <input type="checkbox"/> Cigarettes <input type="checkbox"/> Chewing tobacco <input type="checkbox"/> Vaping products <input type="checkbox"/> Other: _____			
Family History (√ all that apply): <input type="checkbox"/> Unremarkable <input type="checkbox"/> Asthma <input type="checkbox"/> Heart disease/ HTN <input type="checkbox"/> Family Hx of unexpected or sudden death < 50yrs <input type="checkbox"/> Cancer <input type="checkbox"/> High cholesterol <input type="checkbox"/> Diabetes <input type="checkbox"/> Other: _____			
Social Drivers of Health (SDOH) 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) <input type="checkbox"/> Refused to answer	
AAP Screening Recommendations	Assessment/ Tools Used	Low Risk	High Risk (see Plan/ Orders/AG)
Alcohol Misuse Score: _____ <input type="checkbox"/> Refused	<input type="checkbox"/> CRAFFT <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Anemia <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Dental (cavities, no dental home) <input type="checkbox"/> Refused	<input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Depression Score: _____ <input type="checkbox"/> Refused	<input type="checkbox"/> PHQ-9A <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Drug Misuse Score: _____ <input type="checkbox"/> Refused	<input type="checkbox"/> CRAFFT <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Dyslipidemia (Assess risk at each well visit) Lipid Panel once between 17-21 years old <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Hep B (Assess risk at each well visit) Test all 18 yrs and older at least once at earliest opportunity <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> CDC HEP Risk <input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Hep C (Assess risk at each well visit) Test all 18-79 yrs old at least once at earliest opportunity <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> CDC HEP Risk <input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
HIV (Assess risk at each well visit) Test all 15-65 yrs old at least once at earliest opportunity) <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Member Risk Assessment <input type="checkbox"/> Refused	<input type="checkbox"/> Social Needs <input type="checkbox"/> PEARLS <input type="checkbox"/> ACEs <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Psychosocial / Behavioral <input type="checkbox"/> Refused	<input type="checkbox"/> Social Needs <input type="checkbox"/> PEARLS <input type="checkbox"/> ACEs <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Sexually Transmitted Infections <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <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"/> Refused	<input type="checkbox"/> SCD <input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Suicide <input type="checkbox"/> Refused	<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"/> Refused	<input type="checkbox"/> CRAFFT <input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis Exposure <input type="checkbox"/> Refused	<input type="checkbox"/> TB Risk Assessment <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

Comprehensive Health Assessment Form (✓ all that apply)

Name: _____ DOB: _____ MR#: _____

Growth and Development / School Progress (✓ all that apply)		
Grade: _____		
<input type="checkbox"/> Hobbies / work	<input type="checkbox"/> Plays sports	<input type="checkbox"/> Plays / listens to music
<input type="checkbox"/> School achievement / attendance	<input type="checkbox"/> Acts responsibly for self	<input type="checkbox"/> Takes on new responsibility
<input type="checkbox"/> Improved social skills; maintains family relationships	<input type="checkbox"/> Sets goals & works towards achieving them	<input type="checkbox"/> Preparation for further education, career, marriage & parenting
Physical Examination (✓ all that apply)		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 / Gums	Pink, no bleeding/inflammation/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 (✓ all that apply)		
<input type="checkbox"/> Dentist	<input type="checkbox"/> Optometrist/ Ophthalmologist	<input type="checkbox"/> Dietician
<input type="checkbox"/> Drug / ETOH Tx rehab	<input type="checkbox"/> Behavioral health	<input type="checkbox"/> Tobacco cessation class
<input type="checkbox"/> Eating disorder Tx	<input type="checkbox"/> Other: _____	

Orders (✓ all that apply)		
<input type="checkbox"/> COVID 19 vaccine	<input type="checkbox"/> Hep B Panel (at least once ≥18 yrs)	<input type="checkbox"/> CBC / Basic metabolic panel
<input type="checkbox"/> Hep B vaccine (if not up to date)	<input type="checkbox"/> Hep C Antibody test (at least once ≥18 yrs)	<input type="checkbox"/> Hct / Hgb (yearly if menstruating)
<input type="checkbox"/> HPV vaccine (if not up to date)	<input type="checkbox"/> Rx for folic acid 0.4-0.8mg daily (females)	<input type="checkbox"/> Lipid panel (once between 17-21 yrs)
<input type="checkbox"/> Influenza vaccine	<input type="checkbox"/> Chlamydia <input type="checkbox"/> Gonorrhea	<input type="checkbox"/> PPD skin test <input type="checkbox"/> QFT
<input type="checkbox"/> Meningococcal vaccine (if not up to date)	<input type="checkbox"/> HIV (if high risk) <input type="checkbox"/> HIV PrEP	<input type="checkbox"/> CXR <input type="checkbox"/> Urinalysis
<input type="checkbox"/> MMR (if not up to date)	<input type="checkbox"/> Syphilis <input type="checkbox"/> Herpes	<input type="checkbox"/> ECG <input type="checkbox"/> COVID 19 test
<input type="checkbox"/> Tdap	<input type="checkbox"/> Trichomonas	<input type="checkbox"/> Other: _____

Anticipatory Guidance (AG) / Education (✓ if discussed)
 Health education preference: Verbal Visual Multimedia Other: _____

Diet, Nutrition & Exercise

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

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"/> Motor vehicle safety (seat belt /no texting & driving)	<input type="checkbox"/> Personal development & goals in life
<input type="checkbox"/> Safe sex practices (condoms, contraception, HIV/AIDS)	<input type="checkbox"/> Intimate partner violence	<input type="checkbox"/> Testicular self-exam
<input type="checkbox"/> Smoking/vaping Prevention/cessation	<input type="checkbox"/> Skin cancer prevention	<input type="checkbox"/> Self-breast exam

Next Appointment

<input type="checkbox"/> 1 year	<input type="checkbox"/> RTC PRN	<input type="checkbox"/> Other: _____ months _____ weeks _____ days
---------------------------------	----------------------------------	--

Documentation Reminders

<input type="checkbox"/> Screening tools (TB, Depression/Suicide, HEP B, etc.) are completed, dated, & reviewed by PCP	<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)

Member/parent refused the following screening/orders:

Comprehensive Health Assessment Form (√ all that apply)

21 to 39 Years: Female at Birth	Actual Age: _____	Date: _____
Primary Language	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____	
Interpreter Requested (if English is not primary language)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused Name of Interpreter: _____	
Intake	Vital Signs	
Allergies / Reaction	Temp	
Height	BP	
Weight <input type="checkbox"/> Significant loss/gain: _____ lbs	Pulse	
BMI Value	Resp	
Pain	Location: _____ Scale: 0 1 2 3 4 5 6 7 8 9 10	
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		
Advance Health Care Directive AHCD information offered/discussed (review at least every 5 years): <input type="checkbox"/> Yes <input type="checkbox"/> Refused AHCD information <input type="checkbox"/> Has Advanced Directive-requested copy		
Chronic Problems/Significant Conditions: (√ all that apply) <input type="checkbox"/> None <input type="checkbox"/> Asthma <input type="checkbox"/> Cancer <input type="checkbox"/> Depression <input type="checkbox"/> Diabetes <input type="checkbox"/> HTN <input type="checkbox"/> Obesity <input type="checkbox"/> Other: _____		
Functional Limitations (check all that apply): <input type="checkbox"/> Unremarkable <input type="checkbox"/> Seeing <input type="checkbox"/> Hearing <input type="checkbox"/> Mobility <input type="checkbox"/> Communication <input type="checkbox"/> Cognition <input type="checkbox"/> Self-care		
Current Medications/Vitamins: <input type="checkbox"/> None <input type="checkbox"/> See Medication List <input type="checkbox"/> taking 0.4 to 0.8 mg of folic acid daily (for reproductive females)		
Education (last grade completed): _____ Health education preference: <input type="checkbox"/> Verbal <input type="checkbox"/> Visual <input type="checkbox"/> Multimedia <input type="checkbox"/> Other: _____		
Interval History (√ all that apply)		
Dental Home	Dental visit within past 12 months: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental Provider Name: _____	
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)	
Sexual Activity (past 12 months) <input type="checkbox"/> Never had sex <input type="checkbox"/> Currently sexually active <input type="checkbox"/> Not sexually active Current/Past Hx/Risk (√ all that apply): <input type="checkbox"/> Vaginal <input type="checkbox"/> Oral <input type="checkbox"/> Rectal <input type="checkbox"/> New Partner <input type="checkbox"/> Single Partner <input type="checkbox"/> Multiple Partners <input type="checkbox"/> IV Drug use <input type="checkbox"/> STI <input type="checkbox"/> Sex for money		
Contraception Method: <input type="checkbox"/> None <input type="checkbox"/> Condoms <input type="checkbox"/> Other: Planning to conceive within next year: <input type="checkbox"/> Yes <input type="checkbox"/> No		
LMP: ____/____/____	G:____ P:____ A:____	<input type="checkbox"/> Pregnant: EDD ____/____/____ <input type="checkbox"/> Menorrhagia
Alcohol Use (past 12 months) <input type="checkbox"/> Never Used Alcohol <input type="checkbox"/> Current Drinker (assess further) <input type="checkbox"/> Former Drinker (assess further)		
Drug Use (past 12 months) <input type="checkbox"/> Never Used Drugs <input type="checkbox"/> Current User (assess further) <input type="checkbox"/> Former User (assess further) Type used (√ all that apply): <input type="checkbox"/> marijuana <input type="checkbox"/> cocaine <input type="checkbox"/> heroin <input type="checkbox"/> methamphetamine <input type="checkbox"/> prescription meds <input type="checkbox"/> other: _____		
Tobacco Use / Cessation <input type="checkbox"/> Never smoked or used tobacco products <input type="checkbox"/> Current smoker/tobacco user: # Yrs smoked _____ # Cigarettes smoked/day _____ <input type="checkbox"/> Former smoker/tobacco user: # Yrs smoked _____ # Cigarettes smoked/day _____ Quit date _____ Type used: <input type="checkbox"/> Cigarettes <input type="checkbox"/> Chewing tobacco <input type="checkbox"/> Vaping products <input type="checkbox"/> Other: _____		

Name: _____ DOB: _____ MR#: _____

Cervical Cancer	Last PAP: ____/____/____ <input type="checkbox"/> WNL <input type="checkbox"/> Abnormal Last HPV: ____/____/____ <input type="checkbox"/> WNL <input type="checkbox"/> Abnormal		
Intimate Partner Violence (IPV-HITS)	In the last 12 months: Anyone physically hurt you? <input type="checkbox"/> Yes <input type="checkbox"/> No Anyone insulted or humiliated you? <input type="checkbox"/> Yes <input type="checkbox"/> No Anyone threatened you? <input type="checkbox"/> Yes <input type="checkbox"/> No Anyone screamed or cursed at you? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Social Drivers of Health (SDOH)	<input type="checkbox"/> Unremarkable for social drivers of health <input type="checkbox"/> Changes since last visit (move, job, death) <input type="checkbox"/> Problem with housing/food/employment/transportation <input type="checkbox"/> Stressors (mental illness, alcohol/drugs, violence/abuse) <input type="checkbox"/> Refused to answer		
Immunization History and Dates <input type="checkbox"/> None <input type="checkbox"/> See CAIR			
<input type="checkbox"/> COVID #1:	<input type="checkbox"/> Influenza (yearly):	<input type="checkbox"/> Tdap:	
<input type="checkbox"/> COVID #2:			
<input type="checkbox"/> COVID Booster(s):	<input type="checkbox"/> MMR: ____/____/____ + Titer Date: ____/____/____	<input type="checkbox"/> Varicella: ____/____/____ + Titer Date: ____/____/____	
<input type="checkbox"/> Hepatitis B:	<input type="checkbox"/> Pneumococcal:	<input type="checkbox"/> Other: _____	
USPSTF Screening Recommendations	Assessment/Tools Used	Low Risk	High Risk (see Plan/Orders/AG)
Alcohol Misuse Score: _____ <input type="checkbox"/> Refused	<input type="checkbox"/> TAPS <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Cervical Cancer <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Depression Score: _____ <input type="checkbox"/> Refused	<input type="checkbox"/> PHQ2 <input type="checkbox"/> PHQ9 <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Drug Misuse Score: _____ <input type="checkbox"/> Refused	<input type="checkbox"/> TAPS <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Hep B (Assess risk at each well visit) Test all 18 yrs and older at least once at earliest opportunity <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> CDC HEP Risk <input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Hep C (Assess risk at each well visit) Test all 18-79 yrs old at least once at earliest opportunity <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> CDC HEP Risk <input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
HIV (Assess risk at each well visit) Test all 15-65 yrs old at least once at earliest opportunity <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Intimate Partner Violence <input type="checkbox"/> Refused	<input type="checkbox"/> Social Needs <input type="checkbox"/> HARK <input type="checkbox"/> HITS <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Member Risk Assessment <input type="checkbox"/> Refused	<input type="checkbox"/> Social Needs <input type="checkbox"/> ACEs <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Obesity <input type="checkbox"/> Refused	<input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Sexually Transmitted Infections <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> SHA <input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco Use <input type="checkbox"/> Refused	<input type="checkbox"/> TAPS <input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis Exposure <input type="checkbox"/> Refused	<input type="checkbox"/> TB Risk Assessment <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Physical Examination (√ all that apply)			WNL
General appearance	Well-nourished & developed No abuse/neglect evident		<input type="checkbox"/>
Head	No lesions		<input type="checkbox"/>
Eyes	PERRLA, conjunctivae & sclerae clear, Vision grossly normal		<input type="checkbox"/>

Comprehensive Health Assessment Form (√ all that apply)

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 / 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"/>
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 (√ all that apply)		
<input type="checkbox"/> Dentist	<input type="checkbox"/> Optometrist / Ophthalmologist	<input type="checkbox"/> Dietician
<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"/> Eating Disorder Tx	<input type="checkbox"/> Other:
Orders (√ all that apply)		
<input type="checkbox"/> COVID 19 vaccine/ booster	<input type="checkbox"/> COVID 19 test	<input type="checkbox"/> Urinalysis
<input type="checkbox"/> Hep B vaccine (if not up to date)	<input type="checkbox"/> HIV (if high risk)	<input type="checkbox"/> CBC / Basic metabolic panel
<input type="checkbox"/> HPV vaccine (if not up to date)	<input type="checkbox"/> HIV PrEP	<input type="checkbox"/> Hct / Hgb
<input type="checkbox"/> Influenza vaccine	<input type="checkbox"/> Hep B Panel (if at risk)	<input type="checkbox"/> Lipid panel
<input type="checkbox"/> MMR (if not up to date)	<input type="checkbox"/> Hep C Antibody	<input type="checkbox"/> HbA1C
<input type="checkbox"/> Pneumococcal (if high risk)	<input type="checkbox"/> Chlamydia	<input type="checkbox"/> CXR
<input type="checkbox"/> Tdap	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> PPD skin test
<input type="checkbox"/> Varicella (if not up to date)	<input type="checkbox"/> Herpes	<input type="checkbox"/> QFT
<input type="checkbox"/> PAP-cytology	<input type="checkbox"/> Syphilis	<input type="checkbox"/> HCG
<input type="checkbox"/> HPV-lab	<input type="checkbox"/> Trichomonas	<input type="checkbox"/> Folic acid 0.4-0.8mg q day
<input type="checkbox"/> Mammogram	<input type="checkbox"/> Other:	

Name: _____ DOB: _____ MR#: _____

Anticipatory Guidance (AG) / Education (√ if discussed)		
Diet, Nutrition & Exercise		
<input type="checkbox"/> Physical activity / exercise	<input type="checkbox"/> Weight control / obesity	<input type="checkbox"/> Lean protein
<input type="checkbox"/> Whole grains / iron-rich foods	<input type="checkbox"/> Healthy food choices	<input type="checkbox"/> Limit fatty, sugary & salty foods
<input type="checkbox"/> Eating disorder	<input type="checkbox"/> Vegetables, fruits	<input type="checkbox"/> Limit candy, chips & ice cream
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 cessation	<input type="checkbox"/> ASA use	<input type="checkbox"/> Sex education (partner selection)
Next Appointment		
<input type="checkbox"/> 1 year	<input type="checkbox"/> RTC PRN	<input type="checkbox"/> Other: _____ months _____ weeks _____ days

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

MA / Nurse Signature	Title	Date
Provider Signature	Title	Date

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

Comprehensive Health Assessment Form (√ all that apply)

21 to 39 Years: Male at Birth	Actual Age: _____ Date: _____
Primary Language	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____
Interpreter Requested (if English is not primary language)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused Name of Interpreter: _____
Intake	Vital Signs
Allergies / Reaction	Temp _____
Height	BP _____
Weight <input type="checkbox"/> Significant loss/gain: ___ lbs	Pulse _____
BMI Value	Resp _____
Pain	Location: _____ Scale: 0 1 2 3 4 5 6 7 8 9 10
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	
Advance Health Care Directive AHCD information offered/discussed (review at least every 5 years): <input type="checkbox"/> Yes <input type="checkbox"/> Refused AHCD information <input type="checkbox"/> Has Advanced Directive-requested copy	
Chronic Problems/Significant Conditions: (√ all that apply) <input type="checkbox"/> None <input type="checkbox"/> Asthma <input type="checkbox"/> Cancer <input type="checkbox"/> Depression <input type="checkbox"/> Diabetes <input type="checkbox"/> HTN <input type="checkbox"/> Obesity <input type="checkbox"/> Other: _____	
Functional Limitations (check all that apply): <input type="checkbox"/> Unremarkable <input type="checkbox"/> Seeing <input type="checkbox"/> Hearing <input type="checkbox"/> Mobility <input type="checkbox"/> Communication <input type="checkbox"/> Cognition <input type="checkbox"/> Self-care	
Current Medications/Vitamins: <input type="checkbox"/> None <input type="checkbox"/> See Medication List	
Education (last grade completed): _____ Health education preference: <input type="checkbox"/> Verbal <input type="checkbox"/> Visual <input type="checkbox"/> Multimedia <input type="checkbox"/> Other:	
Interval History (√ all that apply)	
Dental Home	Dental visit within past 12 months: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental Provider Name: _____
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: _____
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)
Sexual Activity (past 12 months) <input type="checkbox"/> Never had sex <input type="checkbox"/> Currently sexually active <input type="checkbox"/> Not sexually active Current/Past Hx/Risk (√ all that apply): <input type="checkbox"/> Vaginal <input type="checkbox"/> Oral <input type="checkbox"/> Rectal <input type="checkbox"/> Single Partner <input type="checkbox"/> Multiple Partners <input type="checkbox"/> IV Drug use <input type="checkbox"/> STI <input type="checkbox"/> Men having sex with men	
Contraception Method: <input type="checkbox"/> None <input type="checkbox"/> Condoms <input type="checkbox"/> Other: Planning to conceive within next year: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Alcohol Use (past 12 months) <input type="checkbox"/> Never Used Alcohol <input type="checkbox"/> Current Drinker (assess further) <input type="checkbox"/> Former Drinker: none consumed in the past year (assess further)	
Drug Use (past 12 months) <input type="checkbox"/> Never Used Drugs <input type="checkbox"/> Current User (assess further) <input type="checkbox"/> Former User (assess further) Type used (√ all that apply): <input type="checkbox"/> marijuana <input type="checkbox"/> cocaine <input type="checkbox"/> heroin <input type="checkbox"/> methamphetamine <input type="checkbox"/> prescription meds <input type="checkbox"/> other: _____	
Tobacco Use / Cessation <input type="checkbox"/> Never smoked or used tobacco products <input type="checkbox"/> Current smoker/tobacco user: # Yrs smoked _____ # Cigarettes smoked/day _____ <input type="checkbox"/> Former smoker/tobacco user: # Yrs smoked _____ # Cigarettes smoked/day _____ Quit date _____ Type used: <input type="checkbox"/> Cigarettes <input type="checkbox"/> Chewing tobacco <input type="checkbox"/> Vaping products <input type="checkbox"/> Other:	
Social Drivers of Health (SDOH)	<input type="checkbox"/> Unremarkable for social drivers of health <input type="checkbox"/> Changes since last visit (move, job, death) <input type="checkbox"/> Problems with housing, food, employment, transportation <input type="checkbox"/> Stressors (mental illness, alcohol/drugs, violence/abuse) <input type="checkbox"/> Refused to answer

Name: _____ DOB: _____ MR#: _____

Immunization History / Date	<input type="checkbox"/> None <input type="checkbox"/> See CAIR
<input type="checkbox"/> COVID #1: <input type="checkbox"/> COVID #2: <input type="checkbox"/> COVID Booster(s):	<input type="checkbox"/> Influenza (yearly): <input type="checkbox"/> MMR: + Titer Date: ___/___/___ <input type="checkbox"/> Hepatitis B: <input type="checkbox"/> Pneumococcal: <input type="checkbox"/> Other:
<input type="checkbox"/> Tdap: <input type="checkbox"/> Varicella: + Titer Date: ___/___/___	
USPSTF Screening Recommendations	Assessment/ Tools Used
Alcohol Misuse Score: _____ <input type="checkbox"/> Refused	<input type="checkbox"/> TAPS <input type="checkbox"/> Other: _____
Depression Score: _____ <input type="checkbox"/> Refused	<input type="checkbox"/> PHQ2 <input type="checkbox"/> PHQ9 <input type="checkbox"/> Other: _____
Diabetes <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> H&P <input type="checkbox"/> Other: _____
Drug Misuse Score: _____ <input type="checkbox"/> Refused	<input type="checkbox"/> TAPS <input type="checkbox"/> Other: _____
Hep B (Assess risk at each well visit) Test all 18 yrs and older at least once at earliest opportunity <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> CDC HEP Risk <input type="checkbox"/> H&P <input type="checkbox"/> Other: _____
Hep C (Assess risk at each well visit) Test all 18-79 yrs old at least once at earliest opportunity <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> CDC HEP Risk <input type="checkbox"/> H&P <input type="checkbox"/> Other: _____
HIV (Assess risk at each well visit) Test all 15-65 yrs old at least once at earliest opportunity <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> H&P <input type="checkbox"/> Other: _____
Member Risk Assessment <input type="checkbox"/> Refused	<input type="checkbox"/> Social Needs <input type="checkbox"/> ACEs <input type="checkbox"/> Other: _____
Obesity <input type="checkbox"/> Refused	<input type="checkbox"/> H&P <input type="checkbox"/> Other: _____
Sexually Transmitted Infections <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> SHA <input type="checkbox"/> H&P <input type="checkbox"/> Other: _____
Tobacco Use <input type="checkbox"/> Refused	<input type="checkbox"/> TAPS <input type="checkbox"/> H&P <input type="checkbox"/> Other: _____
Tuberculosis Exposure <input type="checkbox"/> Refused	<input type="checkbox"/> TB Risk Assessment <input type="checkbox"/> Other: _____
Physical Examination (√ all that apply)	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 / Gums	Pink, no bleeding/inflammation/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"/>

Comprehensive Health Assessment Form (√ all that apply)

Male	Circ / uncircumcised, testes in scrotum Prostate Exam / Rectal	<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 (√ all that apply)

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

Orders (√ all that apply)

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

Name: _____ DOB: _____ MR#: _____

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

Diet, Nutrition & Exercise

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

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 cessation	<input type="checkbox"/> Routine dental care	<input type="checkbox"/> Sex education (partner selection)

Next Appointment

<input type="checkbox"/> 1 year	<input type="checkbox"/> RTC PRN	<input type="checkbox"/> Other: _____ months _____ weeks _____ days
---------------------------------	----------------------------------	--

Documentation Reminders

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

MA / Nurse Signature	Title	Date
Provider Signature	Title	Date

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

Member refused the following screening/orders:

Comprehensive Health Assessment Form (√ all that apply)

40 to 49 Years: Female at Birth	Actual Age: _____	Date: _____
Primary Language	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____	
Interpreter Requested <small>(if English is not primary language)</small>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused Name of Interpreter: _____	
Intake	Vital Signs	
Allergies / Reaction	Temp	
Height	BP	
Weight <small>□ Significant loss/gain: _____ lbs</small>	Pulse	
BMI Value	Resp	
Pain	Location: _____ Scale: 0 1 2 3 4 5 6 7 8 9 10	
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		
Advance Health Care Directive AHCD information offered/discussed (review at least every 5 years): <input type="checkbox"/> Yes <input type="checkbox"/> Refused AHCD information <input type="checkbox"/> Has Advanced Directive-requested copy		
Chronic Problems/Significant Conditions (√ all that apply): <input type="checkbox"/> None <input type="checkbox"/> Asthma <input type="checkbox"/> Cancer <input type="checkbox"/> Depression <input type="checkbox"/> Diabetes <input type="checkbox"/> HTN <input type="checkbox"/> Obesity <input type="checkbox"/> Other: _____		
Functional Limitations (check all that apply): <input type="checkbox"/> Unremarkable <input type="checkbox"/> Seeing <input type="checkbox"/> Hearing <input type="checkbox"/> Mobility <input type="checkbox"/> Communication <input type="checkbox"/> Cognition <input type="checkbox"/> Self-care		
Current Medications/Vitamins: <input type="checkbox"/> None <input type="checkbox"/> See Medication List <input type="checkbox"/> taking 0.4 to 0.8 mg of folic acid daily (for reproductive females)		
Education (last grade completed): _____ Health education preference: <input type="checkbox"/> Verbal <input type="checkbox"/> Visual <input type="checkbox"/> Multimedia <input type="checkbox"/> Other: _____		
Interval History (√ all that apply)		
Dental Home	Dental visit within past 12 months: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental Provider Name: _____	
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)	
Sexual Activity (past 12 months) <input type="checkbox"/> Never had sex <input type="checkbox"/> Currently sexually active <input type="checkbox"/> Not sexually active Current/Past Hx/Risk (√ all that apply): <input type="checkbox"/> Vaginal <input type="checkbox"/> Oral <input type="checkbox"/> Rectal <input type="checkbox"/> New Partner <input type="checkbox"/> Single Partner <input type="checkbox"/> Multiple Partners <input type="checkbox"/> IV Drug use <input type="checkbox"/> STI <input type="checkbox"/> Sex for money		
Contraception Method: <input type="checkbox"/> None <input type="checkbox"/> Condoms <input type="checkbox"/> Other: _____ Planning to conceive within next year: <input type="checkbox"/> Yes <input type="checkbox"/> No		
LMP: ___/___/___	G: ___ P: ___ A: ___	<input type="checkbox"/> Pregnant: EDD ___/___/___ <input type="checkbox"/> Menorrhagia <input type="checkbox"/> Menopause
Alcohol Use (past 12 months) <input type="checkbox"/> Never Used Alcohol <input type="checkbox"/> Current Drinker (assess further) <input type="checkbox"/> Former Drinker (assess further)		
Drug Use (past 12 months) <input type="checkbox"/> Never Used Drugs <input type="checkbox"/> Current User (assess further) <input type="checkbox"/> Former User (assess further) Type used (√ all that apply): <input type="checkbox"/> marijuana <input type="checkbox"/> cocaine <input type="checkbox"/> heroin <input type="checkbox"/> methamphetamine <input type="checkbox"/> prescription meds <input type="checkbox"/> other: _____		
Tobacco Use / Cessation <input type="checkbox"/> Never smoked or used tobacco products <input type="checkbox"/> Current smoker/tobacco user: # Yrs smoked _____ # Cigarettes smoked/day _____ <input type="checkbox"/> Former smoker/tobacco user: # Yrs smoked _____ # Cigarettes smoked/day _____ Quit date: _____ Type used: <input type="checkbox"/> Cigarettes <input type="checkbox"/> Chewing tobacco <input type="checkbox"/> Vaping products <input type="checkbox"/> Other: _____		

Name: _____	DOB: _____	MR#: _____	
Cervical Cancer	Last PAP date: _____ <input type="checkbox"/> WNL <input type="checkbox"/> Abnormal Last HPV: _____ <input type="checkbox"/> WNL <input type="checkbox"/> Abnormal Hysterectomy: <input type="checkbox"/> Partial <input type="checkbox"/> Total		
Breast Cancer	Last Mammogram: ___/___/___ <input type="checkbox"/> WNL <input type="checkbox"/> Abnormal		
Colon Cancer	Last Colonoscopy: ___/___/___ <input type="checkbox"/> WNL <input type="checkbox"/> Abnormal Last Colougard: ___/___/___ <input type="checkbox"/> WNL <input type="checkbox"/> Abnormal Last FOBT: ___/___/___ <input type="checkbox"/> WNL <input type="checkbox"/> Abnormal		
Intimate Partner Violence (IPV-HITS)	In the last 12 months: Anyone physically hurt you? <input type="checkbox"/> Yes <input type="checkbox"/> No Anyone insulted or humiliated you? <input type="checkbox"/> Yes <input type="checkbox"/> No Anyone threatened you? <input type="checkbox"/> Yes <input type="checkbox"/> No Anyone screamed or cursed at you? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Social Drivers of Health (SDOH)	<input type="checkbox"/> Unremarkable for social drivers of health <input type="checkbox"/> Changes since last visit (move, job, death) <input type="checkbox"/> Problems with housing, food, employment, transportation <input type="checkbox"/> Stressors (mental illness, alcohol/drugs, violence/abuse) <input type="checkbox"/> Refused to answer		
Immunization History / Date	<input type="checkbox"/> None	<input type="checkbox"/> See CAIR	
<input type="checkbox"/> COVID #1:	<input type="checkbox"/> Influenza (yearly):	<input type="checkbox"/> Tdap:	
<input type="checkbox"/> COVID #2:	<input type="checkbox"/> COVID Booster(s):	<input type="checkbox"/> MMR: _____ + Titer Date: ___/___/___	
		<input type="checkbox"/> Varicella: _____ + Titer Date: ___/___/___ <input type="checkbox"/> Exempt (DOB < 1980 & non-healthcare worker)	
<input type="checkbox"/> Hepatitis B:	<input type="checkbox"/> Pneumococcal:	<input type="checkbox"/> Other:	
USPSTF Screening Recommendations	Assessment/ Tools Used	Low Risk	High Risk <small>(see Plan/ Orders/AG)</small>
Alcohol Misuse Score: _____ <input type="checkbox"/> Refused	<input type="checkbox"/> TAPS <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer (start at 40 yrs old) <input type="checkbox"/> Refused	<input type="checkbox"/> Reports <input type="checkbox"/> H&P <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Cervical Cancer <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> H&P <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Colon Cancer (start at 45 yrs old) <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> Reports <input type="checkbox"/> H&P <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Depression Score: _____ <input type="checkbox"/> Refused	<input type="checkbox"/> PHQ2 <input type="checkbox"/> PHQ9 <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> H&P <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Drug Misuse Score: _____ <input type="checkbox"/> Refused	<input type="checkbox"/> TAPS <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Dyslipidemia (Statin Use) <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> H&P <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Hep B (Assess risk at each well visit) Test all 18 yrs and older at least once at earliest opportunity <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> CDC HEP Risk <input type="checkbox"/> H&P <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Hep C (Assess risk at each well visit) Test all 18-79 yrs old at least once at earliest opportunity <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> CDC HEP Risk <input type="checkbox"/> H&P <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
HIV (Assess risk at each well visit) Test all 15-65 yrs old at least once at earliest opportunity <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> H&P <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Intimate Partner Violence <input type="checkbox"/> Refused	<input type="checkbox"/> Social Needs <input type="checkbox"/> HARK <input type="checkbox"/> HITS <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Member Risk Assessment <input type="checkbox"/> Refused	<input type="checkbox"/> Social Needs <input type="checkbox"/> ACEs <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>

Comprehensive Health Assessment Form (✓ all that apply)

Obesity <input type="checkbox"/> Refused	<input type="checkbox"/> H&P <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis <input type="checkbox"/> Refused	<input type="checkbox"/> H&P <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Sexually Transmitted Infections <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> SHA <input type="checkbox"/> H&P <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco Use <input type="checkbox"/> Refused	<input type="checkbox"/> TAPS <input type="checkbox"/> H&P <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis Exposure <input type="checkbox"/> Refused	<input type="checkbox"/> TB Risk Assessment <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Physical Examination (✓ all that apply)		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 / 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"/>	
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 (✓ all that apply)			
<input type="checkbox"/> Dentist	<input type="checkbox"/> Optometrist / Ophthalmologist	<input type="checkbox"/> Dietician	
<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"/> Eating disorder Tx	<input type="checkbox"/> Other:	

Name: _____ DOB: _____ MR#: _____

Orders (✓ all that apply)		
<input type="checkbox"/> COVID 19 vaccine/booster	<input type="checkbox"/> HIV (if at risk)	<input type="checkbox"/> Urinalysis
<input type="checkbox"/> Hep B vaccine (if not up to date)	<input type="checkbox"/> HIV (PrEP)	<input type="checkbox"/> CBC / Basic metabolic panel
<input type="checkbox"/> Influenza vaccine	<input type="checkbox"/> Hep B Panel (if at risk)	<input type="checkbox"/> Hct / Hgb
<input type="checkbox"/> MMR (if not up to date)	<input type="checkbox"/> Hep C Antibody (if at risk)	<input type="checkbox"/> Lipid panel
<input type="checkbox"/> Pneumococcal (if at risk)	<input type="checkbox"/> Chlamydia	<input type="checkbox"/> PPD skin test
<input type="checkbox"/> Tdap	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> QFT
<input type="checkbox"/> Varicella (if not up to date)	<input type="checkbox"/> Herpes	<input type="checkbox"/> CXR
<input type="checkbox"/> Zoster (if at risk)	<input type="checkbox"/> Syphilis	<input type="checkbox"/> ECG
<input type="checkbox"/> Folic acid 0.4-0.8mg q day	<input type="checkbox"/> Trichomonas	<input type="checkbox"/> HbA1C
<input type="checkbox"/> Low to mod dose statin	<input type="checkbox"/> Colonoscopy	<input type="checkbox"/> Fasting plasma glucose
<input type="checkbox"/> PAP-cytology	<input type="checkbox"/> gFOBT or Fit	<input type="checkbox"/> Bone Density Test
<input type="checkbox"/> HPV-lab	<input type="checkbox"/> Cologuard	<input type="checkbox"/> Mammogram
<input type="checkbox"/> COVID 19 test	<input type="checkbox"/> Other:	
Anticipatory Guidance (AG) / Education (✓ if discussed)		
Diet, Nutrition & Exercise		
<input type="checkbox"/> Physical activity / exercise	<input type="checkbox"/> Healthy food choices	<input type="checkbox"/> Lean protein
<input type="checkbox"/> Weight control / obesity	<input type="checkbox"/> Whole grains / iron-rich foods	<input type="checkbox"/> Limit candy, chips & ice cream
<input type="checkbox"/> Eating disorder	<input type="checkbox"/> Vegetables, fruits	<input type="checkbox"/> Limit fatty, sugary & salty foods
Accident Prevention & Guidance		
<input type="checkbox"/> Alcohol/drug/substance misuse counseling	<input type="checkbox"/> Avoid risk-taking behavior	<input type="checkbox"/> Routine dental care
<input type="checkbox"/> Signs of depression (suicidal ideation)	<input type="checkbox"/> Perimenopause education	<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"/> Intimate partner violence	<input type="checkbox"/> Mindful of daily movements	<input type="checkbox"/> Work 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"/> Sex education (partner selection)	<input type="checkbox"/> Smoking/vaping cessation	<input type="checkbox"/> Self-breast exam
Next Appointment		
<input type="checkbox"/> 1 year	<input type="checkbox"/> RTC PRN	<input type="checkbox"/> Other: ___months ___weeks ___days
Documentation Reminders		
<input type="checkbox"/> Screening tools (TB, Depression, HEP B, etc.) are completed, dated, & reviewed by provider	<input type="checkbox"/> Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)	<input type="checkbox"/> Problem / Medication Lists updated
MA / Nurse Signature	Title	Date
Provider Signature	Title	Date
Notes (include date, time, signature, and title on all entries)		
<input type="checkbox"/> Member refused the following screening/orders:		

Comprehensive Health Assessment Form (√ all that apply)

40 to 49 Years: Male at Birth	Actual Age: _____ Date: _____
Primary Language	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____
Interpreter Requested (if English is not primary language)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused Name of Interpreter: _____
Intake	Vital Signs
Allergies / Reaction	Temp _____
Height	BP _____
Weight <input type="checkbox"/> Significant loss/gain: ___ lbs	Pulse _____
BMI Value	Resp _____
Pain	Location: _____ Scale: 0 1 2 3 4 5 6 7 8 9 10
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	
Advance Health Care Directive AHCD information offered/discussed (review at least every 5 years): <input type="checkbox"/> Yes <input type="checkbox"/> Refused AHCD information <input type="checkbox"/> Has Advanced Directive-requested copy	
Chronic Problems/Significant Conditions: (√ all that apply) <input type="checkbox"/> None <input type="checkbox"/> Asthma <input type="checkbox"/> Cancer <input type="checkbox"/> Depression <input type="checkbox"/> Diabetes <input type="checkbox"/> HTN <input type="checkbox"/> Obesity <input type="checkbox"/> Other: _____	
Functional Limitations (check all that apply): <input type="checkbox"/> Unremarkable <input type="checkbox"/> Seeing <input type="checkbox"/> Hearing <input type="checkbox"/> Mobility <input type="checkbox"/> Communication <input type="checkbox"/> Cognition <input type="checkbox"/> Self-care	
Current Medications/Vitamins: <input type="checkbox"/> None <input type="checkbox"/> See Medication List	
Education (last grade completed): _____ Health education preference: <input type="checkbox"/> Verbal <input type="checkbox"/> Visual <input type="checkbox"/> Multimedia <input type="checkbox"/> Other: _____	
Interval History (√ all that apply)	
Dental Home	Dental visit within past 12 months: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental Provider Name: _____
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: _____
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)
Sexual Activity (past 12 months) <input type="checkbox"/> Never had sex <input type="checkbox"/> Currently sexually active <input type="checkbox"/> Not sexually active Current/Past Hx/Risk (√ all that apply): <input type="checkbox"/> Vaginal <input type="checkbox"/> Oral <input type="checkbox"/> Rectal <input type="checkbox"/> Single Partner <input type="checkbox"/> Multiple Partners <input type="checkbox"/> IV Drug use <input type="checkbox"/> STI <input type="checkbox"/> Men having sex with men	
Contraception Method: <input type="checkbox"/> None <input type="checkbox"/> Condoms <input type="checkbox"/> Other: Planning to conceive within next year: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Alcohol Use (past 12 months) <input type="checkbox"/> Never Used Alcohol <input type="checkbox"/> Current Drinker (assess further) <input type="checkbox"/> Former Drinker (assess further)	
Drug Use (past 12 months) <input type="checkbox"/> Never Used Drugs <input type="checkbox"/> Current User (assess further) <input type="checkbox"/> Former User (assess further) Type used (√ all that apply): <input type="checkbox"/> marijuana <input type="checkbox"/> cocaine <input type="checkbox"/> heroin <input type="checkbox"/> methamphetamine <input type="checkbox"/> prescription meds <input type="checkbox"/> other: _____	
Tobacco Use / Cessation <input type="checkbox"/> Never smoked or used tobacco products <input type="checkbox"/> Current smoker/tobacco user: # Yrs smoked _____ # Cigarettes smoked/day _____ <input type="checkbox"/> Former smoker/tobacco user: # Yrs smoked _____ # Cigarettes smoked/day _____ Quit date _____ Type used: <input type="checkbox"/> Cigarettes <input type="checkbox"/> Chewing tobacco <input type="checkbox"/> Vaping products <input type="checkbox"/> Other: _____	
Colon Cancer	Last Colonoscopy: ___/___/___ <input type="checkbox"/> WNL <input type="checkbox"/> Abnormal Last Cologuard: ___/___/___ <input type="checkbox"/> WNL <input type="checkbox"/> Abnormal Last FOBT: ___/___/___ <input type="checkbox"/> WNL <input type="checkbox"/> Abnormal

Name: _____ DOB: _____ MR#: _____

Social Drivers of Health (SDOH)	<input type="checkbox"/> Unremarkable for social drivers of health <input type="checkbox"/> Changes since last visit (move, job, death) <input type="checkbox"/> Problems with housing, food, employment, transportation <input type="checkbox"/> Refused <input type="checkbox"/> Stressors (mental illness, alcohol/drugs, violence/abuse)		
Immunization History / Date	<input type="checkbox"/> None <input type="checkbox"/> See CAIR		
<input type="checkbox"/> COVID #1: _____ <input type="checkbox"/> Influenza (yearly): _____ <input type="checkbox"/> Tdap: _____ <input type="checkbox"/> COVID #2: _____			
<input type="checkbox"/> COVID Booster(s): _____ <input type="checkbox"/> MMR: _____ + Titer Date: ___/___/___ <input type="checkbox"/> Varicella: _____ + Titer Date: ___/___/___ <input type="checkbox"/> Exempt (DOB < 1980 & non-healthcare worker)			
<input type="checkbox"/> Hepatitis B: _____ <input type="checkbox"/> Pneumococcal: _____ <input type="checkbox"/> Other: _____			
USPSTF Screening Recommendations	Assessment/Tools Used	Low Risk	High Risk (see Plan/Orders/AG)
Alcohol Misuse Score: _____ <input type="checkbox"/> Refused	<input type="checkbox"/> TAPS <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Colon Cancer (start at 45 yrs old) <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> Reports <input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Depression Score: _____ <input type="checkbox"/> Refused	<input type="checkbox"/> PHQ2 <input type="checkbox"/> PHQ9 <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Drug Misuse Score: _____ <input type="checkbox"/> Refused	<input type="checkbox"/> TAPS <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Dyslipidemia (Statin Use) <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Hep B (Assess risk at each well visit) Test all 18 yrs and older at least once at earliest opportunity <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> CDC HEP Risk <input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Hep C (Assess risk at each well visit) Test all 18-79 yrs old at least once at earliest opportunity <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> CDC HEP Risk <input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
HIV (Assess risk at each well visit) Test all 15-65 yrs old at least once at earliest opportunity <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Member Risk Assessment <input type="checkbox"/> Refused	<input type="checkbox"/> Social Needs <input type="checkbox"/> ACEs <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Obesity <input type="checkbox"/> Refused	<input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Sexually Transmitted Infections <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> SHA <input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco Use <input type="checkbox"/> Refused	<input type="checkbox"/> TAPS <input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis Exposure <input type="checkbox"/> Refused	<input type="checkbox"/> TB Risk Assessment <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Physical Examination (√ all that apply)	WNL		
General appearance	Well-nourished & developed No abuse/neglect evident	<input type="checkbox"/>	<input type="checkbox"/>
Head	No lesions	<input type="checkbox"/>	<input type="checkbox"/>
Eyes	PERRLA, conjunctivae & sclerae clear Vision grossly normal	<input type="checkbox"/>	<input type="checkbox"/>
Ears	Canals clear, TMs normal Hearing grossly normal	<input type="checkbox"/>	<input type="checkbox"/>
Nose	Passages clear, MM pink, no lesions	<input type="checkbox"/>	<input type="checkbox"/>
Teeth	No visible cavities, grossly normal	<input type="checkbox"/>	<input type="checkbox"/>

Comprehensive Health Assessment Form (√ all that apply)

Mouth / Gums	Pink, no bleeding/inflammation/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	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 (√ all that apply)		
<input type="checkbox"/> Dentist	<input type="checkbox"/> Optometrist / Ophthalmologist	<input type="checkbox"/> Dietician
<input type="checkbox"/> Drug / ETOH Tx rehab	<input type="checkbox"/> Behavioral health	<input type="checkbox"/> Tobacco cessation class
<input type="checkbox"/> Eating Disorder Tx	<input type="checkbox"/> Other:	
Orders (√ all that apply)		
<input type="checkbox"/> COVID 19 vaccine/ booster	<input type="checkbox"/> HIV (if at risk)	<input type="checkbox"/> Urinalysis
<input type="checkbox"/> Hep B vaccine (if not up to date)	<input type="checkbox"/> HIV (PrEP)	<input type="checkbox"/> CBC / Basic metabolic panel
<input type="checkbox"/> Influenza vaccine	<input type="checkbox"/> Hep B Panel (if at risk)	<input type="checkbox"/> Hct / Hgb
<input type="checkbox"/> MMR (if not up to date)	<input type="checkbox"/> Hep C Antibody (if at risk)	<input type="checkbox"/> Lipid panel
<input type="checkbox"/> Pneumococcal	<input type="checkbox"/> Chlamydia	<input type="checkbox"/> ECG
<input type="checkbox"/> Tdap	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> CXR
<input type="checkbox"/> Varicella	<input type="checkbox"/> Herpes	<input type="checkbox"/> PPD skin test
<input type="checkbox"/> Zoster (if at risk)	<input type="checkbox"/> Syphilis	<input type="checkbox"/> QFT
<input type="checkbox"/> Colonoscopy	<input type="checkbox"/> gFOBT or Fit	<input type="checkbox"/> Fasting plasma glucose
<input type="checkbox"/> Low to mod dose statin	<input type="checkbox"/> Cologuard	<input type="checkbox"/> HbA1C
<input type="checkbox"/> COVID 19 test	<input type="checkbox"/> Other:	

Name: _____ DOB: _____ MR#: _____

Anticipatory Guidance (AG) / Education (√ if discussed)		
Diet, Nutrition & Exercise		
<input type="checkbox"/> Physical activity / exercise	<input type="checkbox"/> Healthy food choices	<input type="checkbox"/> Lean protein
<input type="checkbox"/> Weight control / obesity	<input type="checkbox"/> Whole grains / iron-rich foods	<input type="checkbox"/> Limit candy, chips & ice cream
<input type="checkbox"/> Eating disorder	<input type="checkbox"/> Vegetables, fruits	<input type="checkbox"/> Limit fatty, sugary & salty foods
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 cessation	<input type="checkbox"/> Routine dental care	<input type="checkbox"/> Sex education (partner selection)
Next Appointment		
<input type="checkbox"/> 1 year	<input type="checkbox"/> RTC PRN	<input type="checkbox"/> Other: _____ months _____ weeks _____ days

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

MA / Nurse Signature	Title	Date
Provider Signature	Title	Date

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

Comprehensive Health Assessment Form (√ all that apply)

50+ Years: Female at Birth	Actual Age: _____ Date: _____
Primary Language	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____
Interpreter Requested (if English is not primary language)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused Name of Interpreter: _____
Intake	Vital Signs
Allergies / Reaction	Temp
Height	BP
Weight <input type="checkbox"/> Significant loss/gain: _____ lbs	Pulse
BMI Value	Resp
Pain	Location: _____ Scale: 0 1 2 3 4 5 6 7 8 9 10
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	
Advance Health Care Directive AHCD information offered/discussed (review at least every 5 years): <input type="checkbox"/> Yes <input type="checkbox"/> Refused AHCD information <input type="checkbox"/> Has Advanced Directive-requested copy	
Chronic Problems/Significant Conditions (√ all that apply): <input type="checkbox"/> None <input type="checkbox"/> Asthma <input type="checkbox"/> Cancer <input type="checkbox"/> Depression <input type="checkbox"/> Diabetes <input type="checkbox"/> HTN <input type="checkbox"/> Obesity <input type="checkbox"/> Other: _____	
Functional Limitations (check all that apply): <input type="checkbox"/> Unremarkable <input type="checkbox"/> Seeing <input type="checkbox"/> Hearing <input type="checkbox"/> Mobility <input type="checkbox"/> Communication <input type="checkbox"/> Cognition <input type="checkbox"/> Self-care	
Current Medications/Vitamins: <input type="checkbox"/> None <input type="checkbox"/> See Medication List	
Education (last grade completed): _____ Health education preference: <input type="checkbox"/> Verbal <input type="checkbox"/> Visual <input type="checkbox"/> Multimedia <input type="checkbox"/> Other: _____	
Interval History (√ all that apply)	
Dental Home	Dental visit within past 12 months: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental Provider Name: _____
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)
Sexual Activity (past 12 months) <input type="checkbox"/> Never had sex <input type="checkbox"/> Currently sexually active <input type="checkbox"/> Not sexually active Current/Past Hx/Risk (√ all that apply): <input type="checkbox"/> Vaginal <input type="checkbox"/> Oral <input type="checkbox"/> Rectal <input type="checkbox"/> New Partner <input type="checkbox"/> Single Partner <input type="checkbox"/> Multiple Partners <input type="checkbox"/> IV Drug use <input type="checkbox"/> STI <input type="checkbox"/> Sex for money	
Contraception Method: <input type="checkbox"/> None <input type="checkbox"/> Condoms <input type="checkbox"/> Other: _____	
Alcohol Use (past 12 months) <input type="checkbox"/> Never Used Alcohol <input type="checkbox"/> Current Drinker (assess further) <input type="checkbox"/> Former Drinker (assess further)	
Drug Use (past 12 months) <input type="checkbox"/> Never Used Drugs <input type="checkbox"/> Current User (assess further) <input type="checkbox"/> Former User (assess further) Type used (√ all that apply): <input type="checkbox"/> marijuana <input type="checkbox"/> cocaine <input type="checkbox"/> heroin <input type="checkbox"/> methamphetamine <input type="checkbox"/> prescription meds <input type="checkbox"/> other: _____	
Tobacco Use / Cessation <input type="checkbox"/> Never smoked or used tobacco products <input type="checkbox"/> Current smoker/tobacco user: # Yrs smoked _____ # Cigarettes smoked/day _____ <input type="checkbox"/> Former smoker/tobacco user: # Yrs smoked _____ # Cigarettes smoked/day _____ Quit date: _____ Type used: <input type="checkbox"/> Cigarettes <input type="checkbox"/> Chewing tobacco <input type="checkbox"/> Vaping products <input type="checkbox"/> Other: _____	

Name: _____ DOB: _____ MR#: _____

LMP: ___/___/___	G:___ P:___ A:___	<input type="checkbox"/> Menopause <input type="checkbox"/> Menorrhagia	
Cervical Cancer	Last PAP date: _____ <input type="checkbox"/> WNL <input type="checkbox"/> Abnormal Last HPV: _____ <input type="checkbox"/> WNL <input type="checkbox"/> Abnormal <input type="checkbox"/> Hysterectomy: <input type="checkbox"/> Partial <input type="checkbox"/> Total		
Breast Cancer	Last Mammogram: ___/___/___ <input type="checkbox"/> WNL <input type="checkbox"/> Abnormal		
Colon Cancer	Last Colonoscopy: ___/___/___ <input type="checkbox"/> WNL <input type="checkbox"/> Abnormal Last Cologuard: ___/___/___ <input type="checkbox"/> WNL <input type="checkbox"/> Abnormal Last FOBT: ___/___/___ <input type="checkbox"/> WNL <input type="checkbox"/> Abnormal		
Social Drivers of Health (SDOH)	<input type="checkbox"/> Unremarkable for social drivers of health <input type="checkbox"/> Changes since last visit (move, job, death) <input type="checkbox"/> Problems with housing, food, employment, transportation <input type="checkbox"/> Stressors (mental illness, alcohol/drugs, violence/abuse) <input type="checkbox"/> Refused to answer		
Immunization History / Date	<input type="checkbox"/> None <input type="checkbox"/> Tdap: <input type="checkbox"/> See CAIR		
<input type="checkbox"/> COVID #1: <input type="checkbox"/> COVID #2:	<input type="checkbox"/> Influenza (yearly): <input type="checkbox"/> Zoster:		
<input type="checkbox"/> COVID Booster(s):	<input type="checkbox"/> MMR: + Titer Date: ___/___/___ <input type="checkbox"/> Exempt (DOB < 1957 & non-healthcare worker)	<input type="checkbox"/> Varicella: + Titer Date: ___/___/___ <input type="checkbox"/> Exempt (DOB < 1980 & non-healthcare worker)	
<input type="checkbox"/> Hepatitis B:	<input type="checkbox"/> Pneumococcal: <input type="checkbox"/> Other:		
USPSTF Screening Recommendations	Assessment/ Tools Used	Low Risk	High Risk (see Plan/ Orders/AG)
Alcohol Misuse Score: _____ <input type="checkbox"/> Refused	<input type="checkbox"/> TAPS <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer <input type="checkbox"/> Refused	<input type="checkbox"/> Reports <input type="checkbox"/> H&P <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Cervical Cancer <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> H&P <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Cognitive Health (start at 65 yrs old) Score: _____ *May be used as member risk assessment <input type="checkbox"/> Refused	<input type="checkbox"/> MINI-COG <input type="checkbox"/> AD8 <input type="checkbox"/> H&P <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Colon Cancer <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> Reports <input type="checkbox"/> H&P <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Depression Score: _____ <input type="checkbox"/> Refused	<input type="checkbox"/> PHQ2 <input type="checkbox"/> PHQ9 <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> H&P <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Drug Misuse Score: _____ <input type="checkbox"/> Refused	<input type="checkbox"/> TAPS <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Dyslipidemia (Statin Use) <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> H&P <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Hep B (Assess risk at each well visit) Test all 18 yrs and older at least once at earliest opportunity <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> CDC HEP Risk , <input type="checkbox"/> H&P <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Hep C (Assess risk at each well visit) Test all 18-79 yrs old at least once at earliest opportunity <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> CDC HEP Risk <input type="checkbox"/> H&P <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
HIV (Assess risk at each well visit) Test all 15-65 yrs old at least once at earliest opportunity <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> H&P <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Lung Cancer (CT Scan) Current/former smokers aged 50-80 yrs old w/ Hx of 20-pack year use <input type="checkbox"/> Refused	<input type="checkbox"/> Reports <input type="checkbox"/> H&P <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Member Risk Assessment <input type="checkbox"/> Refused	<input type="checkbox"/> SDOH <input type="checkbox"/> ACEs <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>

Comprehensive Health Assessment Form (√ all that apply)

Obesity	<input type="checkbox"/> Refused	<input type="checkbox"/> H&P <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/> Refused	<input type="checkbox"/> Reports <input type="checkbox"/> H&P <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Sexually Transmitted Infections	<input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> SHA <input type="checkbox"/> H&P <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco Use	<input type="checkbox"/> Refused	<input type="checkbox"/> TAPS <input type="checkbox"/> H&P <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis Exposure	<input type="checkbox"/> Refused	<input type="checkbox"/> TB Risk Assessment <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Physical Examination (√ all that apply)			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 / 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"/>	
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 (√ all that apply)				
<input type="checkbox"/> Dentist	<input type="checkbox"/> Optometrist / Ophthalmologist	<input type="checkbox"/> Dietician		
<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"/> Eating disorder Tx	<input type="checkbox"/> Other:		

Name:

DOB:

MR#:

Orders (√ all that apply)		
<input type="checkbox"/> COVID 19 vaccine/booster	<input type="checkbox"/> COVID 19 test	<input type="checkbox"/> Urinalysis
<input type="checkbox"/> Hep B vaccine (if not up to date)	<input type="checkbox"/> HIV (if at risk)	<input type="checkbox"/> CBC / Basic metabolic panel
<input type="checkbox"/> Influenza vaccine	<input type="checkbox"/> HIV (PrEP)	<input type="checkbox"/> Hct / Hgb
<input type="checkbox"/> MMR (if not up to date)	<input type="checkbox"/> Hep B Panel	<input type="checkbox"/> Lipid panel
<input type="checkbox"/> Pneumococcal	<input type="checkbox"/> Hep C Antibody	<input type="checkbox"/> PPD skin test
<input type="checkbox"/> Tdap	<input type="checkbox"/> Chlamydia	<input type="checkbox"/> QFT
<input type="checkbox"/> Varicella (if not up to date)	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> CXR
<input type="checkbox"/> Zoster	<input type="checkbox"/> Herpes	<input type="checkbox"/> ECG
<input type="checkbox"/> PAP-cytology	<input type="checkbox"/> Syphilis	<input type="checkbox"/> HbA1C
<input type="checkbox"/> HPV-lab	<input type="checkbox"/> Trichomonas	<input type="checkbox"/> Fasting plasma glucose
<input type="checkbox"/> Low Dose CT (20-pack year smoking history & currently smoke or have quit within past 15 years)	<input type="checkbox"/> Colonoscopy	<input type="checkbox"/> Bone Density Test
	<input type="checkbox"/> Cologuard	<input type="checkbox"/> Mammogram
	<input type="checkbox"/> gFOBT or Fit	<input type="checkbox"/> Low to mod dose statin
<input type="checkbox"/> Other:		
Anticipatory Guidance (AG) / Education (√ if discussed)		
Diet, Nutrition & Exercise		
<input type="checkbox"/> Physical activity / exercise	<input type="checkbox"/> Healthy food choices	<input type="checkbox"/> Lean protein
<input type="checkbox"/> Weight control / obesity	<input type="checkbox"/> Whole grains / iron-rich foods	<input type="checkbox"/> Limit candy, chips & ice cream
<input type="checkbox"/> Eating disorder	<input type="checkbox"/> Vegetables, fruits	<input type="checkbox"/> Limit fatty, sugary & salty foods
Accident Prevention & Guidance		
<input type="checkbox"/> Alcohol/drug/substance misuse counseling	<input type="checkbox"/> Routine dental care	<input type="checkbox"/> Independence
<input type="checkbox"/> Signs of depression (suicidal ideation)	<input type="checkbox"/> Gun safety	<input type="checkbox"/> Personal development
<input type="checkbox"/> Mental health (emotional support)	<input type="checkbox"/> Goals in life	<input type="checkbox"/> Aging process
<input type="checkbox"/> Diabetes management	<input type="checkbox"/> Mindful of daily movements	<input type="checkbox"/> Work or retirement activities
<input type="checkbox"/> 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 cessation	<input type="checkbox"/> Perimenopause education	<input type="checkbox"/> Self-breast exam
Next Appointment		
<input type="checkbox"/> 1 year	<input type="checkbox"/> RTC PRN	<input type="checkbox"/> Other: ___months ___weeks ___days
MA / Nurse Signature	Title	Date
Provider Signature	Title	Date
Notes (include date, time, signature, and title on all entries)		
<input type="checkbox"/> Member refused the following screening/orders:		

Comprehensive Health Assessment Form (√ all that apply)

50+ Years: Male at Birth	Actual Age: _____ Date: _____
Primary Language	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____
Interpreter Requested (if English is not primary language)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused Name of Interpreter: _____
Intake	Vital Signs
Allergies / Reaction	Temp _____
Height	BP _____
Weight <input type="checkbox"/> Significant loss/gain: _____ lbs	Pulse _____
BMI Value	Resp _____
Pain	Location: _____ Scale: 0 1 2 3 4 5 6 7 8 9 10
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	
Advance Health Care Directive AHCD information offered/discussed (review at least every 5 years): <input type="checkbox"/> Yes <input type="checkbox"/> Refused AHCD information <input type="checkbox"/> Has Advanced Directive-requested copy	
Chronic Problems/Significant Conditions (√ all that apply): <input type="checkbox"/> None <input type="checkbox"/> Asthma <input type="checkbox"/> Cancer <input type="checkbox"/> Depression <input type="checkbox"/> Diabetes <input type="checkbox"/> HTN <input type="checkbox"/> Obesity <input type="checkbox"/> Other: _____	
Functional Limitations (check all that apply): <input type="checkbox"/> Unremarkable <input type="checkbox"/> Seeing <input type="checkbox"/> Hearing <input type="checkbox"/> Mobility <input type="checkbox"/> Communication <input type="checkbox"/> Cognition <input type="checkbox"/> Self-care	
Current Medications/Vitamins: <input type="checkbox"/> None <input type="checkbox"/> See Medication List	
Education (last grade completed): _____ Health education preference: <input type="checkbox"/> Verbal <input type="checkbox"/> Visual <input type="checkbox"/> Multimedia <input type="checkbox"/> Other: _____	
Interval History (√ all that apply)	
Dental Home	Dental visit within past 12 months: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental Provider Name: _____
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)
Sexual Activity (past 12 months) <input type="checkbox"/> Never had sex <input type="checkbox"/> Currently sexually active <input type="checkbox"/> Not sexually active Current/Past Hx/Risk (√ all that apply): <input type="checkbox"/> Vaginal <input type="checkbox"/> Oral <input type="checkbox"/> Rectal <input type="checkbox"/> Single Partner <input type="checkbox"/> Multiple Partners <input type="checkbox"/> IV Drug use <input type="checkbox"/> STI <input type="checkbox"/> Men having sex with men	
Contraception Method: <input type="checkbox"/> None <input type="checkbox"/> Condoms <input type="checkbox"/> Other: _____	
Alcohol Use (past 12 months) <input type="checkbox"/> Never Used Alcohol <input type="checkbox"/> Current Drinker (assess further) <input type="checkbox"/> Former Drinker: none consumed in the past year (assess further)	
Drug Use (past 12 months) <input type="checkbox"/> Never Used Drugs <input type="checkbox"/> Current User (assess further) <input type="checkbox"/> Former User (assess further) Type used (√ all that apply): <input type="checkbox"/> marijuana <input type="checkbox"/> cocaine <input type="checkbox"/> heroin <input type="checkbox"/> methamphetamine <input type="checkbox"/> prescription meds <input type="checkbox"/> other: _____	
Tobacco Use / Cessation <input type="checkbox"/> Never smoked or used tobacco products <input type="checkbox"/> Current smoker/tobacco user: # Yrs smoked _____ # Cigarettes smoked/day _____ <input type="checkbox"/> Former smoker/tobacco user: # Yrs smoked _____ # Cigarettes smoked/day _____ Quit date: _____ Type used: <input type="checkbox"/> Cigarettes <input type="checkbox"/> Chewing tobacco <input type="checkbox"/> Vaping products <input type="checkbox"/> Other: _____	

Name: _____ DOB: _____ MR#: _____

Colon Cancer	Last Colonoscopy: ___/___/___ <input type="checkbox"/> WNL <input type="checkbox"/> Abnormal Last Cologuard: ___/___/___ <input type="checkbox"/> WNL <input type="checkbox"/> Abnormal Last FOBT: ___/___/___ <input type="checkbox"/> WNL <input type="checkbox"/> Abnormal		
Social Drivers of Health (SDOH)	<input type="checkbox"/> Unremarkable for social drivers of health <input type="checkbox"/> Changes since last visit (move, job, death) <input type="checkbox"/> Problems with housing, food, employment, transportation <input type="checkbox"/> Refused <input type="checkbox"/> Stressors (mental illness, alcohol/drugs, violence/abuse)		
Immunization History / Date	<input type="checkbox"/> None <input type="checkbox"/> Tdap: _____ <input type="checkbox"/> See CAIR		
<input type="checkbox"/> COVID #1: <input type="checkbox"/> COVID #2:	<input type="checkbox"/> Influenza (yearly): _____ <input type="checkbox"/> Zoster: _____		
<input type="checkbox"/> COVID Booster(s):	<input type="checkbox"/> MMR: _____ + Titer Date: ___/___/___ <input type="checkbox"/> Exempt (DOB <1957 & non-healthcare worker) <input type="checkbox"/> Varicella: _____ + Titer Date: ___/___/___ <input type="checkbox"/> Exempt (DOB < 1980 & non-healthcare worker)		
<input type="checkbox"/> Hepatitis B:	<input type="checkbox"/> Pneumococcal: _____ <input type="checkbox"/> Other: _____		
USPSTF Screening Recommendations	Assessment/ Tools Used	Low Risk	High Risk (see Plan/Orders/AG)
Abdominal Aortic Aneurism Ultrasound for 65-75 yrs old who smoked 100+ cigs in lifetime <input type="checkbox"/> Refused	<input type="checkbox"/> Reports <input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol Misuse Score: _____ <input type="checkbox"/> Refused	<input type="checkbox"/> TAPS <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Cognitive Health (start at 65 yrs old) Score: _____ *May be used as member risk assessment <input type="checkbox"/> Refused	<input type="checkbox"/> MINI-COG <input type="checkbox"/> AD8 <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Colon Cancer <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> Reports <input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Depression Score: _____ <input type="checkbox"/> Refused	<input type="checkbox"/> PHQ2 <input type="checkbox"/> PHQ9 <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Drug Misuse Score: _____ <input type="checkbox"/> Refused	<input type="checkbox"/> TAPS <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Dyslipidemia (Statin Use) <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Hep B (Assess risk at each well visit) Test all 18 yrs and older at least once at earliest opportunity <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> CDC HEP Risk <input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Hep C (Assess risk at each well visit) Test all 18-79 yrs old at least once at earliest opportunity <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> CDC HEP Risk <input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
HIV (Assess risk at each well visit) Test all 15-65 yrs old at least once at earliest opportunity <input type="checkbox"/> Refused	<input type="checkbox"/> Labs <input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Lung Cancer (CT Scan) Current/former smokers aged 50-80 yrs old w/ Hx of 20-pack year use <input type="checkbox"/> Refused	<input type="checkbox"/> Reports <input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Member Risk Assessment <input type="checkbox"/> Refused	<input type="checkbox"/> Social Needs <input type="checkbox"/> ACEs <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Obesity <input type="checkbox"/> Refused	<input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Sexually Transmitted Infections <input type="checkbox"/> Refused	<input type="checkbox"/> SHA <input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco Use <input type="checkbox"/> Refused	<input type="checkbox"/> TAPS <input type="checkbox"/> H&P <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis Exposure <input type="checkbox"/> Refused	<input type="checkbox"/> TB Risk Assessment <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

Comprehensive Health Assessment Form (√ all that apply)

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

Physical Examination (√ all that apply)		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 / Gums	Pink, no bleeding/inflammation/lesions	<input type="checkbox"/>
Neck	Supple, no masses, thyroid not enlarged	<input type="checkbox"/>
Chest	Symmetrical, no masses	<input type="checkbox"/>
Heart	No organic murmurs, regular rhythm	<input type="checkbox"/>
Lungs	Clear to auscultation bilaterally	<input type="checkbox"/>
Abdomen	Soft, no masses, liver & spleen normal	<input type="checkbox"/>
Genitalia	Grossly normal	<input type="checkbox"/>
Male	Circ /uncircumcised, testes in scrotum Prostate Exam / Rectal	<input type="checkbox"/>
Femoral pulses	Present & equal	<input type="checkbox"/>
Extremities	No deformities, full ROM	<input type="checkbox"/>
Lymph nodes	Not enlarged	<input type="checkbox"/>
Back	No scoliosis	<input type="checkbox"/>
Skin	Clear, no significant lesions	<input type="checkbox"/>
Neurologic	Alert, no gross sensory or motor deficit	<input type="checkbox"/>
Subjective / Objective		
Assessment		
Plan		
Referrals (√ all that apply)		
<input type="checkbox"/> Dentist	<input type="checkbox"/> Optometrist / Ophthalmologist	<input type="checkbox"/> Dietician
<input type="checkbox"/> Drug / ETOH Tx rehab	<input type="checkbox"/> Behavioral health	<input type="checkbox"/> Tobacco cessation class
<input type="checkbox"/> Eating disorder Tx	<input type="checkbox"/> Other: _____	
Orders (√ all that apply)		
<input type="checkbox"/> COVID 19 vaccine/ booster	<input type="checkbox"/> HIV (if high risk)	<input type="checkbox"/> Urinalysis
<input type="checkbox"/> Hep B vaccine (if not up to date)	<input type="checkbox"/> HIV (PrEP)	<input type="checkbox"/> CBC / Basic metabolic panel
<input type="checkbox"/> Influenza vaccine	<input type="checkbox"/> Hep B Panel (if at risk)	<input type="checkbox"/> Hct / Hgb
<input type="checkbox"/> MMR (if not up to date)	<input type="checkbox"/> Hep C Antibody (if at risk)	<input type="checkbox"/> Lipid panel
<input type="checkbox"/> Pneumococcal	<input type="checkbox"/> Chlamydia	<input type="checkbox"/> ECG
<input type="checkbox"/> Tdap	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> CXR

<input type="checkbox"/> Varicella (if not up to date)	<input type="checkbox"/> Herpes	<input type="checkbox"/> PPD skin test
<input type="checkbox"/> Zoster	<input type="checkbox"/> Syphilis	<input type="checkbox"/> QFT
<input type="checkbox"/> Colonoscopy	<input type="checkbox"/> gFOBT or Fit	<input type="checkbox"/> Fasting plasma glucose
<input type="checkbox"/> Low to mod dose statin	<input type="checkbox"/> Cologuard	<input type="checkbox"/> HbA1C
<input type="checkbox"/> Low Dose CT (20-pack year smoking history & currently smoke or have quit within past 15 years)	<input type="checkbox"/> AAA Ultrasound (65 to 75 who have ever smoked >100 cigarettes in lifetime)	<input type="checkbox"/> PSA <input type="checkbox"/> COVID 19 test

Other: _____

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

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

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

Next Appointment

<input type="checkbox"/> 1 year	<input type="checkbox"/> RTC PRN	<input type="checkbox"/> Other: _____ months _____ weeks _____ days
---------------------------------	----------------------------------	--

Documentation Reminders

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

MA / Nurse Signature	Title	Date
Provider Signature	Title	Date

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

<input type="checkbox"/> Member refused the following screening/orders: