

Comprehensive Health Assessment

12 to 15 Months Old	Actual Age: _____	Date: _____
Medical Record #		
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Accompanied by	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other:	
Parent's Primary Language		
Interpreter Requested	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused	
Name of Interpreter		
Intake	Vital Signs	
Allergies	Temp	
Height	Pulse	
Weight	Resp	
Head Circumference		
Pain	Location: Scale: 0 1 2 3 4 5 6 7 8 9 10	
Dental Provider	Last visit date: _____	
Chronic Problems/Significant Conditions: <input type="checkbox"/> See Problem List		
Current Medications/Vitamins: <input type="checkbox"/> See Medication List		
Interval History		
Diet / Nutrition	<input type="checkbox"/> Regular <input type="checkbox"/> Iron-rich foods <input type="checkbox"/> Other:	
Elimination	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Has WIC	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Physical Activity	<input type="checkbox"/> Inactive (little or none) <input type="checkbox"/> Some (< 30 min/day) <input type="checkbox"/> Active (> 30 min/day)	
Sleep	<input type="checkbox"/> Regular <input type="checkbox"/> Sleep regression <input type="checkbox"/> Night time fears	
Fluoridated Water Supply	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Fluoride Varnish	Date last applied: _____	
Vaccines Up to Date	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> See CAIR	
Family History	<input type="checkbox"/> Unremarkable <input type="checkbox"/> Diabetes	
<input type="checkbox"/> Heart disease	<input type="checkbox"/> HTN	<input type="checkbox"/> Asthma
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Cancer	<input type="checkbox"/> Family Hx of unexpected or sudden death < 50 YO
<input type="checkbox"/> Other: _____		
Psychosocial & Behavioral Assessment, Family/Social Factors	<input type="checkbox"/> WNL - Stable relationships w/ social/emotional support <input type="checkbox"/> Changes in family since last visit (move, job, death) <input type="checkbox"/> Problems with housing, food, employment <input type="checkbox"/> Family stressors (mental illness, drugs, violence/abuse)	
Lives with	<input type="checkbox"/> 1 Parent <input type="checkbox"/> 2 Parents <input type="checkbox"/> Other: _____	

Name: _____

DOB: _____

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

Comprehensive Health Assessment

Subjective / Objective		
Assessment		
Plan		
Referrals		
<input type="checkbox"/> WIC	<input type="checkbox"/> Optometrist / Ophthalmologist	<input type="checkbox"/> Audiologist
<input type="checkbox"/> Dentist	<input type="checkbox"/> Dietician / Nutritionist	<input type="checkbox"/> Pulmonologist
<input type="checkbox"/> CA Children's Services (CCS)	<input type="checkbox"/> Regional Center	<input type="checkbox"/> Early Start or Local Education Agency
<input type="checkbox"/> Other:		
Orders		
<input type="checkbox"/> COVID 19 vaccine	<input type="checkbox"/> Meningococcal (if high risk)	<input type="checkbox"/> CBC / Basic metabolic panel
<input type="checkbox"/> DTaP	<input type="checkbox"/> MMR	<input type="checkbox"/> Hct / Hgb (at 12 months)
<input type="checkbox"/> Hep A vaccine	<input type="checkbox"/> PCV	<input type="checkbox"/> Lipid panel (if high risk)
<input type="checkbox"/> Hep B vaccine	<input type="checkbox"/> Varicella	<input type="checkbox"/> PPD skin test <input type="checkbox"/> QFT
<input type="checkbox"/> Hib	<input type="checkbox"/> Hep B Panel (if high risk)	<input type="checkbox"/> CXR <input type="checkbox"/> Urinalysis
<input type="checkbox"/> Influenza vaccine	<input type="checkbox"/> Blood Lead (at 12 months)	<input type="checkbox"/> ECG <input type="checkbox"/> COVID 19 test
<input type="checkbox"/> IPV	<input type="checkbox"/> Rx Fluoride drops / chewable tabs 0.25-0.50 mg QD	<input type="checkbox"/> Fluoride varnish application
<input type="checkbox"/> Other:		

Name:

DOB:

Anticipatory Guidance (AG) / Education (✓ if discussed)		
Diet, Nutrition & Exercise		
<input type="checkbox"/> Weight control / obesity	<input type="checkbox"/> Vegetables, fruits	<input type="checkbox"/> Table food
<input type="checkbox"/> Whole grains / iron-rich foods	<input type="checkbox"/> Encourage solids	<input type="checkbox"/> Using cup
<input type="checkbox"/> Physical activity / exercise	<input type="checkbox"/> Healthy food choices	<input type="checkbox"/> No bottles in bed
Accident Prevention & Guidance		
<input type="checkbox"/> Lead poisoning prevention	<input type="checkbox"/> Rear facing toddler car seat	<input type="checkbox"/> Feeding self
<input type="checkbox"/> Routine dental care	<input type="checkbox"/> Choking hazards	<input type="checkbox"/> Simple games
<input type="checkbox"/> Brush teeth with fluoride toothpaste	<input type="checkbox"/> Storage of drugs / toxic chemicals	<input type="checkbox"/> Temper tantrum
<input type="checkbox"/> Fluoride varnish treatment	<input type="checkbox"/> Matches / burns	<input type="checkbox"/> Family play
<input type="checkbox"/> Family support, social interaction & communication	<input type="checkbox"/> Violence prevention, gun safety	<input type="checkbox"/> Mindful of daily movements
<input type="checkbox"/> Caution with strangers	<input type="checkbox"/> Poison control phone number	<input type="checkbox"/> Treatment of minor cuts
<input type="checkbox"/> Skin cancer prevention	<input type="checkbox"/> Smoke detector	<input type="checkbox"/> Limit screen time
<input type="checkbox"/> Falls	<input type="checkbox"/> Hot water temp < 120° F	<input type="checkbox"/> Bedtime
<input type="checkbox"/> Effects of passive smoking	<input type="checkbox"/> Drowning / pool fence	<input type="checkbox"/> Toileting habits / training
Next Appointment		
<input type="checkbox"/> 1 year	<input type="checkbox"/> RTC PRN	<input type="checkbox"/> Other:

Documentation Reminders		
<input type="checkbox"/> Staying Healthy Assessment / IHEBA forms reviewed, completed, dated, & signed by provider	<input type="checkbox"/> Weight & Head Circumference measurements plotted in WHO growth chart	<input type="checkbox"/> Vaccines entered in CAIR (manufacturer, lot #, VIS publication dates, etc.)

MA / Nurse Signature	Title	Date
Provider Signature	Title	Date

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