

## Comprehensive Health Assessment

<b>7 to 9 Months Old</b>	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		
<b>Intake</b>		<b>Vital Signs</b>
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		
<b>Interval History</b>		
Diet / Nutrition	<input type="checkbox"/> Regular <input type="checkbox"/> Iron-rich foods <input type="checkbox"/> Other:	
Feedings	<input type="checkbox"/> Breastfed every _____ hours <input type="checkbox"/> Formula _____oz every _____ hours Formula Type or Brand: _____	
Elimination	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Has WIC	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Sleep	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
Sleep Position	<input type="checkbox"/> Supine <input type="checkbox"/> Prone <input type="checkbox"/> Side	
Fluoridated Water Supply	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Fluoride Varnish	Date last applied: _____	
Vaccines Up to Date	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> See <a href="#">CAIR</a>	
<b>Family History</b>	<input type="checkbox"/> Unremarkable	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Heart disease	<input type="checkbox"/> HTN	<input type="checkbox"/> Asthma
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Cancer	<input type="checkbox"/> Family Hx of unexpected or sudden death < 50 YO
<input type="checkbox"/> Other: _____		
Psychosocial & Behavioral Assessment, Family/Social Factors	<input type="checkbox"/> WNL - Stable relationships w/ social/emotional support <input type="checkbox"/> Changes in family since last visit (move, job, death) <input type="checkbox"/> Problems with housing, food, employment <input type="checkbox"/> Family stressors (mental illness, drugs, violence/abuse)	
Lives with	<input type="checkbox"/> 1 Parent <input type="checkbox"/> 2 Parents <input type="checkbox"/> Other: _____	

Name:

DOB:

AAP Risk Screener	Screening Tools Used	Low Risk	High Risk (see Plan/Orders/AG)
Blood Lead	<input type="checkbox"/> <a href="#">Lead Assessment</a> , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Dental (cavities, no dental home)	<input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Developmental Disorder (9 Months)	<input type="checkbox"/> <a href="#">ASQ-3</a> , <input type="checkbox"/> <a href="#">SWYC</a> , <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"/> <a href="#">PEARLS</a> , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Psychosocial / Behavioral	<input type="checkbox"/> <a href="#">PSC</a> , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco Use / Exposure	<input type="checkbox"/> <a href="#">SHA</a> , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis Exposure	<input type="checkbox"/> <a href="#">TB Risk Assessment</a> , <input type="checkbox"/> H&P, <input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>
<b>Growth and Development</b>			
<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	
<b>Physical Examination</b>			<b>WNL</b>
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"/>	

