

Comprehensive Health Assessment

Under 1 Month 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		
Birth History	Birth Weight: _____	Gestation: _____
Delivery	<input type="checkbox"/> Vaginal <input type="checkbox"/> C-Section	Complications <input type="checkbox"/> Yes <input type="checkbox"/> No
OB/GYN Provider		
Post-Partum Appointment Date		
Cord	<input type="checkbox"/> Absent <input type="checkbox"/> Present <input type="checkbox"/> Redness/swelling <input type="checkbox"/> Yellow drainage	
Chronic Problems/Significant Conditions: <input type="checkbox"/> See Problem List		
Current Medications/Vitamins: <input type="checkbox"/> See Medication List		
Interval History		
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	
Has WIC	<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	<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"/> Childhood hearing impairment	<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)
Maternal Depression	<input type="checkbox"/> EPDS, <input type="checkbox"/> PHQ-9, <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"/> PAPE, <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"/> 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			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 / Palate	Oral mucosa pink, 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			

