

Comprehensive Health Assessment

16 to 23 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"/>
Autism Disorder (18 Months)	<input type="checkbox"/> ASQ-3, <input type="checkbox"/> SWYC, <input type="checkbox"/> M-CHAT, <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"/>
Developmental Disorder (18 Months)	<input type="checkbox"/> ASQ-3, <input type="checkbox"/> SWYC, <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 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			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, leg length equal	<input type="checkbox"/>	
Femoral pulses	Normal	<input type="checkbox"/>	
Extremities	No deformities, full ROM	<input type="checkbox"/>	

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Skin	Clear, no significant lesions	<input type="checkbox"/>
Neurologic	Alert, no gross sensory or motor deficit	<input type="checkbox"/>
Subjective / Objective		
Assessment		
Plan		
Referrals		
<input type="checkbox"/> WIC	<input type="checkbox"/> Optometrist / Ophthalmologist	<input type="checkbox"/> Audiologist
<input type="checkbox"/> Dentist	<input type="checkbox"/> Dietician / Nutritionist	<input type="checkbox"/> Pulmonologist
<input type="checkbox"/> CA Children's Services (CCS)	<input type="checkbox"/> Regional Center	<input type="checkbox"/> Early Start or Local Education Agency
<input type="checkbox"/> Other:		
Orders		
<input type="checkbox"/> COVID 19 vaccine	<input type="checkbox"/> 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 0.25-0.50 mg QD (PRN through age 4)	<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:

Anticipatory Guidance (AG) / Education (✓ if discussed)		
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"/> 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"/> 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)