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| **Initial Medical Exam** |
| **General Information** (to be completed by shelter staff) |
| **Child** | Last name: | First name: |
| DOB:  \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ | A#: | Gender: |
| **Healthcare Provider**  | Name:  **MD / DO / PA / NP**  | Phone number: | Clinic or Practice: |
| Street address: | City or Town: | State: | Date of visit: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ |
| **Program**  | Name of program staff with child: | Program name: |
| **History and Physical Assessment** (to be completed by provider) |
| **Vital Signs** |
| T (Co):  | HR: | BP (> 3 years): | RR:  | Ht (cm):  | Wt (kg):  |
|  **Allergies** | * Check if none
 |
| * Food, specify:
 | * Medication, specify:
 | * Other, specify:
 |
| **Vision** (> 5 years) |
|  | **Right Eye** | **Left Eye** | **Both eyes** |
| Corrected | 20 / | 20 / | 20 / |
| Uncorrected | 20 / | 20 / | 20 / |
| **Medical History** |
| Concerns expressed by child or caregiver: | * No concerns
 |
| Past medical history (include surgeries and hospital admissions):  |
| Family History: |
| Reproductive History:   | LMP: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_ or  | * N/A
 | Previous pregnancy: G \_\_\_\_\_\_\_ P \_\_\_\_\_\_\_ or  | * N/A
 |
| **Review of Systems (ROS)** |
| **Check all applicable signs and symptoms and enter the date each began:** |
| * No abnormal findings
 |  | * Pain, location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | \_\_\_/\_\_\_\_/\_\_\_\_ |
| * Fever (>37.8 Co) or chills
 | \_\_\_/\_\_\_\_/\_\_\_\_ | * Red eyes
 | \_\_\_/\_\_\_\_/\_\_\_\_ |
| * Runny nose
 | \_\_\_/\_\_\_\_/\_\_\_\_ | * Sore throat
 | \_\_\_/\_\_\_\_/\_\_\_\_ |
| * Cough
 | \_\_\_/\_\_\_\_/\_\_\_\_ | * Difficulty breathing/Shortness of breath/ Wheezing
 | \_\_\_/\_\_\_\_/\_\_\_\_ |
| * Nausea
 | \_\_\_/\_\_\_\_/\_\_\_\_ | * Vomiting
 | \_\_\_/\_\_\_\_/\_\_\_\_ |
| * Diarrhea
 | \_\_\_/\_\_\_\_/\_\_\_\_ | * Neck stiffness
 | \_\_\_/\_\_\_\_/\_\_\_\_ |
| * Headache
 | \_\_\_/\_\_\_\_/\_\_\_\_ | * Confusion/Altered mental status
 | \_\_\_/\_\_\_\_/\_\_\_\_ |
| * Dizziness
 | \_\_\_/\_\_\_\_/\_\_\_\_ | * Neurologic symptoms
 | \_\_\_/\_\_\_\_/\_\_\_\_ |
| * Skin lesions or rash
 | \_\_\_/\_\_\_\_/\_\_\_\_ | * Yellow skin or eyes
 | \_\_\_/\_\_\_\_/\_\_\_\_ |
| * Swollen glands
 | \_\_\_/\_\_\_\_/\_\_\_\_ | * Unusual bleeding
 | \_\_\_/\_\_\_\_/\_\_\_\_ |
| * Other, specify: \_\_\_/\_\_\_\_/\_\_\_\_
 |

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| **Physical Examination** |
| **Check each system to indicate if normal or abnormal. If abnormal, describe. Leave blank if not evaluated:** |
| **System** | **Normal** |  **Abnormal** |
| General appearance |  | * Specify:
 |
| HEENT |  | * Specify:
 |
| Neck |  | * Specify:
 |
| Heart |  | * Specify:
 |
| Lungs |  | * Specify:
 |
| Abdomen |  | * Specify:
 |
| GU/GYN |  | * Specify:
 |
| Extremities |  | * Specify:
 |
| Abdomen |  | * Specify:
 |
| Back/Spine |  | * Specify:
 |
| Neurologic |  | * Specify:
 |
| Skin (include tattoos) |  | * Specify:
 |
| Other: \_\_\_\_\_\_\_\_\_\_\_\_\_ |  | * Specify:
 |

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| **Psychosocial Risk**  |
| **In each section, place a check next to each reported condition**/**history/behavior & describe where applicable:** |
| **Mental Health** (Over the past 3 months) | * Check if no concerns
 |
| * Feels empty, hopeless, sad, numb more often than not
 | * Has trouble concentrating, restless, too many thoughts
 |
| * Feels constantly worried, anxious, nervous more often than not
 | * Has trouble eating, sleeping
 |
| * Experiences mood swings, from very high to very low
 | * Feels helpless
 |
| * Reliving traumatic events from the past
 | * Feels like hurting others
 |
| * Feels easily annoyed or irritated
 | * Feels like hurting self, would be better off dead
 |
| * Feels afraid, easily startled, jumpy
 | * Other concerns:
 |
| **Physical Abuse History** | * Check if abuse is denied
 |
| * Victim of physical abuse, specify who/when/where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | * In home country
 |
| * During journey to U.S.
 |
| **Sexual Activity/Abuse History** | * Check if sexual activity or abuse are denied
 |
| * Consensual sexual activity (oral/vaginal/anal)
 |
| * Sexual abuse, specify who/when/where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | * In home country
 |
| * During journey to U.S.
 |
| * Previous STD, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| **Substance Abuse** | * Check if substance use is denied
 |
| * IVDU:
 | * Alcohol:
 | * Tobacco:
 | * Other:
 |

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| **Laboratory Testing** |
| **Ordered** | **Test** | **Indicators** | **Result** |
| **Positive** | **Negative** | **Indeterminate** |
|  | Flu, rapid | Fever + cough or sore throat |  |  |  |
|  | HIV  | > 13 yrs or Sexual activity/abuse |  |  |  |
|  | Pregnancy  | >10 yrs or Sexual activity/abuse |  |  |  |
|  | Lead **(positive >5** **mcg/dl)** | 6 mos - 6 yrs |  |  |  |
|  | Hepatitis B surface antigen | Sexual activity/abuse, IVDU |  |  |  |
|  | Hepatitis C antibody | IVDU |  |  |  |
|  | Syphilis RPR/VRDL | Sexual activity/abuse |  |  |  |
|  | Chlamydia NAAT | Sexual activity/abuse |  |  |  |
|  | Gonorrhea NAAT | Sexual activity/abuse |  |  |  |

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|  **TB Screening** (Use Appendix A for result documentation) |
| Has child ever been a close contact to someone with ***active*** TB disease? | * No
 | * Yes, specify:
 |
| Has child ever been treated for ***active*** TB disease? | * No
 | * Yes, specify:
 |
| Has child ever been treated for ***latent*** TB infection? | * No
 | * Yes, specify:
 |
| **TB screening method ordered:** | * TST (any age)
 | * IGRA (5-15 yrs)
 | * CXR (>15 yrs)
 | * Was or will be tested elsewhere
 |

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| **Assessment and Plan** |
| **Assessment:**  Check all that apply. If “Other” is selected, specify in the space provided.  |
| * **Well-child** (Only check if no other condition present)

**General/Constitutional*** Dehydration
* Allergy (drug reaction, food allergy, etc.)
* Malnourished
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEENT*** Headache/migraine
* Vision issues
* Hearing issues
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Respiratory/Pulmonary** * Asthma
* Influenza or influenza-like illness (ILI)
* Upper/lower respiratory illness (not ILI)
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cardiovascular*** Heart murmur
* Syncope/fainting
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Gastrointestinal** * Gastroenteritis
* Heartburn/reflux
* Intestinal parasites (e.g., tapeworms)
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Genito-urinary/Reproductive*** Childbirth
* Pregnancy/pregnancy-related
* Urinary tract infection
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Neurological** * Developmental delay
* Seizure/epilepsy
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | **Skin and Hair*** Lice
* Scabies
* Dermatitis/rash (not acne)
* Cellulitis
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Potentially Reportable Infectious Disease**

|  |  |
| --- | --- |
| * Acute hepatitis A
 | * Acute/chronic hepatitis B
 |
| * Acute/chronic hepatitis C
 | * Chikungunya
 |
| * Chlamydia
 | * Dengue
 |
| * Gonorrhea
 | * HIV
 |
| * Malaria
 | * Measles
 |
| * Mumps
 | * Pertussis
 |
| * Rubella
 | * Sepsis/Meningitis
 |
| * Syphilis
 | * TB
 |
| * Typhoid fever
 | * Varicella
 |
| * Viral hemorrhagic fever, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |

**Abuse*** Sexual
* Physical
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Injury*** Fracture
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Other, Medical:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Behavioral and Mental Health Concerns**

|  |  |
| --- | --- |
| * ADHD/ADD
 | * Adjustment disorder
 |
| * Anxiety disorder
 | * Bipolar disorder
 |
| * Borderline personality disorder
 | * Depressive disorder
 |
| * Panic disorder
 | * PTSD
 |
| * Schizophrenia
 | * Self-injury/cutting
 |
| * Suicide ideation/attempt
 | * Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |

 |
| **Plan:** Check all that apply and specify in the space provided. |
| Return to clinic:* PRN/As needed
* Follow-up (specify condition, timing): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| * Referred to specialist/counselor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| * Prolonged treatment/therapy (e.g., physical therapy): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| * New/Current medications (specify name, reason, date started, dose, and directions and check if psychotropic):
 |
| 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | * Psychotropic
 |
| 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | * Psychotropic
 |
| 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 | * Psychotropic
 |
| * Immunizations given/validated from foreign record (Please ensure that shelter staff receive a copy of the immunization record)
* List immunizations not given due to medical contraindication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| * Age-appropriate anticipatory guidance discussed and/or handout given
 |
| * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| **Additional Information:** |

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