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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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