OMB Control No: 0970-XXXX
Expiration date: XX/XX/XXXX

# 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 (C°): | 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 C°) 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: | | | ___/____/____ |

| 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: |

**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: |

**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 | € | € | € |

**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 |

**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
2. _____ € Psychotropic
3. _____ € 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:**