

Diplomate: \_\_\_\_\_

**CLINICAL PRACTICE EVALUATION I:  
MEDICAL RECORD REVIEW (Pediatric Patient Population)**

**A. RECORD IDENTIFIER INFORMATION**

1. Date medical record reviewed (mm/dd/year):        /        /
2. Patient identifier: \_\_\_\_\_
3. Date of patient's most recent visit (mm/dd/year):        /        /
4. Patient's gender:    Female    Male
5. Patient's age: \_\_\_\_\_

**B. HISTORY**

1. Does the patient's medical record document an initial history during his/her first visit to your practice?    Yes    No
2. Does the patient's medical record document an interval history at the following ages?

| Age       | Yes                      | No                       | N/A                      | Age       | Yes                      | No                       | N/A                      | Age      | Yes                      | No                       | N/A                      |
|-----------|--------------------------|--------------------------|--------------------------|-----------|--------------------------|--------------------------|--------------------------|----------|--------------------------|--------------------------|--------------------------|
| Prenatal  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 24 months | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 12 years | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Newborn   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 30 months | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 13 years | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3-5 days  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 3 years   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 14 years | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1 month   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 4 years   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 15 years | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2 months  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 5 years   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 16 years | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4 months  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 6 years   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 17 years | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6 months  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 7 years   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 18 years | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9 months  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 8 years   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 19 years | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12 months | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 9 years   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 20 years | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 15 months | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 10 years  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 21 years | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 18 months | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 11 years  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |          |                          |                          |                          |

**C. OBJECTIVE FINDINGS**

Physical findings at the most recent examination:

Head circumference        \_\_\_\_\_in

Height/length                \_\_\_\_\_in

Weight                         \_\_\_\_\_lb

Body Mass Index             \_\_\_\_\_

Blood Pressure              \_\_\_\_\_mmHg

**D. SCREENING**

Has the patient received the following screening tests within the recommended intervals?

1. Newborn Screening:

- Congenital Hypothyroidism      Yes    No    Unsure    N/A
- Hearing Loss                            Yes    No    Unsure    N/A
- Phenylketonuria                        Yes    No    Unsure    N/A
- Sickle Cell Disease                      Yes    No    Unsure    N/A

*(USPSTF Recommendations: All newborns)*

2. Childhood Screening:

- Visual Impairment
  - Amblyopia                                Yes    No    Unsure    N/A
  - Strabismus                                Yes    No    Unsure    N/A
  - Defects in visual acuity                Yes    No    Unsure    N/A

*(USPSTF Recommendations: Children younger than age 5)*

3. Adolescent Screenings:

- Cervical cancer                            Yes    No    Unsure    N/A

*(USPSTF Recommendation: Women who have been sexually active and have a cervix, starting at age 21 or within 3 years of onset of sexual activity (whichever occurs earlier)*

- Chlamydia                                 Yes    No    Unsure    N/A

*(USPSTF Recommendation: All sexually active non-pregnant young women (up to age 24)*

- Depression                                 Yes    No    Unsure    N/A

*(USPSTF Recommendation: When systems are in place to ensure accurate diagnosis, psychotherapy and follow-up)*

- Gonorrhea                                 Yes    No    Unsure    N/A

*(USPSTF Recommendation: All sexually active young women at increased risk)*

- HIV                                         Yes    No    Unsure    N/A

*(USPSTF Recommendation: All adolescents at increased risk)*

**E. INTERVENTION**

Which of the following have been recommended to the patient?

**1. Counseling**

STI counseling

*(USPSTF Recommendation: All sexually active adolescents at increased risk)*

Others (please specify): \_\_\_\_\_

None of the above

**2. Chemoprevention**

Oral fluoride supplementation

*(USPSTF Recommendation: Preschool children older than 6 months of age whose primary water source is deficient in fluoride)*

Hepatitis A vaccination

12-23 mo  18-23 mo (2 doses at least 6 months apart)

Hepatitis B vaccination

Birth  1-2 mo  6-18 mo

Human Papillomavirus

11-12 yrs(#1)  11-12 yrs(#2)  11-12 yrs(#3) OR

13-18 yrs(#1)  13-18 yrs(#2)  11-18 yrs(#3) (if not previously vaccinated)

Rotavirus vaccination

6-14 wk  3-4 mo  6-8 mo (if indicated)

Diphtheria, Tetanus, Pertussis vaccination

6-8 wk  2-4 mo  4-6 mo  12-18 mo  4-6 yrs

11-12 yrs  13-18 yrs (if indicated)

Haemophilus influenzae type b vaccination

6-8 wk  2-4 mo  4-6 mo (if indicated)  12-18 mo

Inactivated Poliovirus vaccination

1-2 mo  2-4 mo  6-18 mo  4-6 yrs (if indicated)

Influenza vaccination

*(ACIP recommendation: Annually ages 6 months-18 years)*

Measles, mumps, rubella (MMR) vaccination

12-18 mo  4-6 yrs

Meningococcal vaccination

2-10 years (if high risk)  11-12 (all)  13-18 (if not previously vaccinated)

Pneumococcal vaccination

6-8 wk  2-4 mo  4-6 mo  12-18 mo  2-18 yrs (if high risk)

Varicella vaccination

12-18 mo  4-6 yrs

Others (*please specify*): \_\_\_\_\_

None of the above

**3. Do any of the following limit the patient's ability to engage in age-appropriate activities?**

Psychiatric illness or cognitive impairment

Yes  No  Unsure

Problems with adherence

Yes  No  Unsure

Other medical conditions

Yes  No  Unsure

Social factors

Yes  No  Unsure

**END OF MEDICAL RECORD REVIEW FOR THIS PATIENT**