WELL ADOLESCENT 11 to 20 YEARS

VACCINES: P C

Today's Date:_____

Patient Name:_____ Date of Birth:_____

FAMILY HISTORY:

Changes in household since last visit ___**Yes** ___**No** Explain_____
Adolescent Lives with: ___Mother ___Father ___Grandparent ___Stepparent Other_____
Primary Caregiver: ___Mother ___Father ___Grandparent ___Other_____
Family Concerns/Problems: Explain_____

Does mother or father have high cholesterol levels? ___Yes ___No

Is there history of early heart attacks in the family (Males younger than 45 years old, women younger than 55 years old)? **__Yes ___No**

NUTRITION:

1. Does your child have any recurrent problems with therapeutic diet, self-prescribed diet, inappropriate weight gain/loss, anemic, chronic GI problems, major food allergies, refusal of any food groups? ___**Yes** ___**No** (circle any that apply, explain)
List: _____
2. Number of usual servings per day: **(example: 1, 2, 3)**
___Dairy ___Fruits ___Vegetables
___Bread, cereal, rice and pasta
___Meat, poultry, fish, eggs and dry beans

CHILD HEALTH: Indicate Yes/No or Check ☑ any that apply.

1. Does adolescent have any food or drug allergies? ___ **Yes** ___**No** List_____
2. Does adolescent **smoke or use tobacco**___**Yes** ___**No;** use **alcohol**___**Yes** ___**No**; use **illegal drugs**___**Yes** ___**No**
3. Has this adolescent had any major illness, surgeries, injuries or hospitalizations? ___**Yes** ___**No**
List:_____
4. Does this adolescent take any medications regularly? ___**Yes** ___**No**_____
5. Has this adolescent seen a dentist or scheduled for a dental appointment? ___**Yes** ___**No**
6. **(Female only)** Menstrual: Age of Menarche _____, Frequency of menses ___days, Duration of days ____
Other problems_____

IMMUNIZATIONS: Check ☑ Yes or No

___**Yes** ___**NO** Should the **RECOMMENDED OR MISSED** vaccines be administered to your child today?

SENSORY:

Vision Screen: **Indicate Yes or No**

1. Does this adolescent seem to see well? ___**Yes** ___**No**

Hearing Screen:

1. Does this adolescent seem to hear well? ___**Yes** ___**No**
2. Does this adolescent seem to increase the volume of the TV or radio? ___**Yes** ___**No**

MENTAL HEALTH: Check ☑ any that apply. Check here ☐ if no problems are noted.

____Sleep Problems ___Behavior problems ___Relationship problems with parents, siblings, peers
___Problems in school ___Adjustment to pubertal changes ___No extracurricular activities
___Excessive extracurricular activities ___Substance abuse/use ___Depression/suicidal thoughts ___Contact with juvenile legal/justice system ___School-age parent/pregnant ___Eating disorders ___Sexually active ___Physical/sexual abuse
___Risk taking behavior ___Body Image Problems

What is your grade level? _____
Known history of neglect, physical, sexual or emotional abuse, prenatal substance abuse: ___**Yes** ___**No**
Explain: _____

REVIEW OF SYSTEMS: Check ☑ any that apply. Check here ☐ if no problems are noted.

Skin: ___Rashes ___Acne ___Moles ___Warts ___Tattoos
Eyes: ___Eye Discharge ___Deviation ___Poor vision ___Excessive blinking ___glasses
Ears: ___Hearing problems ___Ear infections
Nose/Mouth/Throat: ___Frequent colds ___Nasal Congestion ___Nasal Discharge ___Sore throat
Dental: ____Caries ___Braces
Cardio: ___History of murmur ___Palpitations ___Chest Pain ___Sports endurance
Respiratory: ___Cough ___Shortness of breath ___Wheezing ___Asthma ___TB
Gastrointestinal: ___Abdominal pain ___Frequent bowel Movements ____Vomiting
Genitourinary: ____Burning with urination ___Penile/vaginal discharge ___Vaginal itching/burning
Neuromuscular: ____Seizures ____Dizziness
Musculoskeletal: ____Fractures ____Joint pain ___Sports injury

Form Complete:_____(staff initials)

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Today's Date:_____

Patient Name:_____ Date of Birth:_____

Vitals: Weight:_____ Height:_____ Resp: _____ Pulse: _____ Temp:_____ B/P _____

Audioscope Screening: Testing by _____ ___20 db ___25 db ___40 db

	500	1000	2000	4000
Right Ear				
Left Ear				

FOR OFFICE USE ONLY

PHYSICAL EXAM:	**Normal**	**Abnormal**	**Comments**
Appearance	_____	_____	_____
Head/fontanels	_____	_____	_____
Skin/nodes	_____	_____	_____
Eyes:	_____	_____	VA: OD_____ OS_____ Correction___ No correction___
Symmetric Corneal light reflex	_____	_____	_____
Conjugate gaze bilaterally	_____	_____	_____
Ears	_____	_____	_____
Nose	_____	_____	_____
Mouth/Throat	_____	_____	_____
Teeth	_____	_____	_____
Neck	_____	_____	_____
Chest/breasts (Tanner stage)_____		_____	_____
Heart/Pulses	_____	_____	_____
Lungs	_____	_____	_____
Abdomen	_____	_____	_____
Genitalia/anus(Tanner stage)_____		_____	_____
Spine/Hips	_____	_____	_____
Extremities	_____	_____	_____
Muscle Tone	_____	_____	_____
DTRs	_____	_____	_____

ASSESSMENT: **1. Well Adolescent Exam** **2.**_____

3. _____ **4.**_____

PLAN: Immunizations: ___Vaccinations up to date

Required Immunizations: ___ PPD ___Tdap ___ Varicella #2 ___MCV4 (meningococcal) ___ HPV (recommended)

Flu Vaccine: ___Seasonal ___HINI ___Seasonal + H1N1

___Parent declines (List)_____

Lab: **___Hct/Hgb Medicaid Required Age 12 and 16** Other Labs:_____

EPSDT TB Questionnaire (Medicaid Required ages 11-20): ___TB questionnaire given

Referral made to : _____

Dental: Parent advised to make Preventive Dental Appointment: _____

Health Education Handout Given to Parent/Guardian _____

RTC in: _____months/prn _____yr/prn