

NAME: _____
 DOB: _____
 GENDER: MALE FEMALE
 DATE OF SERVICE: _____

MEDICAID ID: _____
 PRIMARY CARE GIVER: _____
 PHONE: _____
 INFORMANT: _____

HISTORY

See new patient history form

INTERVAL HISTORY:

NKDA Allergies: _____

Last Menstrual Period: _____

Menstrual Cycle # Days: _____

Current Medications: _____

Visits to other health-care providers, facilities: _____

Parental concerns/changes/stressors in family or home: _____

Psychosocial/Behavioral Health Issues: Y N
 Findings: _____

DEVELOPMENTAL SCREENING:

Use of standardized tool (required once 12-18 years):
 PSC-17 PSC-35 Y-PSC PHQ-9 CRAFFT
 P F Findings: _____

TB questionnaire*, risk identified: Y N
 *Tuberculin Skin Test if indicated TST
 (See back for form)

NUTRITION*:

Problems: Y N
 Assessment: _____

*See Bright Futures Nutrition Book if needed

IMMUNIZATIONS

Up-to-date
 Deferred - Reason: _____

Given today: Hep A* Hep B HPV IPV
 Td/Tdap Meningococcal MMR
 Pneumococcal* Varicella Influenza

*Special populations: See ACIP

LABORATORY

Tests ordered today: _____

UNCLOTHED PHYSICAL EXAM

See growth graph

Weight: _____ (_____ %) Height: _____ (_____ %)

BMI: _____ (_____ %) Heart Rate: _____

Blood Pressure: _____ / _____ Respiratory Rate: _____

Temperature (optional): _____

Normal (Mark here if all items are WNL)

Abnormal (Mark all that apply and describe):

- | | | |
|-------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Appearance | <input type="checkbox"/> Nose | <input type="checkbox"/> Lungs |
| <input type="checkbox"/> Head | <input type="checkbox"/> Mouth/throat | <input type="checkbox"/> GI/abdomen |
| <input type="checkbox"/> Skin | <input type="checkbox"/> Teeth | <input type="checkbox"/> Extremities |
| <input type="checkbox"/> Eyes | <input type="checkbox"/> Neck | <input type="checkbox"/> Back |
| <input type="checkbox"/> Ears | <input type="checkbox"/> Heart | <input type="checkbox"/> Musculoskeletal |
| | | <input type="checkbox"/> Neurological |

Abnormal findings: _____

Additional:

Tanner Stage _____

Breasts _____ /5 Genitalia _____ /5

Subjective Hearing Screening: P F

Subjective Vision Screening: P F

HEALTH EDUCATION/ANTICIPATORY GUIDANCE (See back for useful topics)

Selected health topics addressed in any of the following areas*:

- Physical Growth and Development
- Nutrition
- Social and Academic Competence
- Safety

*See Bright Futures for assistance

ASSESSMENT

PLAN/REFERRALS

Dental Referral: Y

Other Referral(s) _____

Return to office: _____

Signature/title _____

Signature/title _____

Name:

Medicaid ID:

Typical Developmentally Appropriate Health Education Topics

13 Year Old Checkup

- Provide nutritious meals and snacks; limit sweets/sodas/high-fat foods
- Discuss puberty and physical changes/sexuality
- Encourage constructive conflict resolution, demonstrate anger management at home
- Encourage personal hygiene routine
- Encourage physical activity for 1 hour/day
- Establish consistent limits/rules and consistent consequences
- Increase difficulty of chores to develop sense of family responsibility/self-accomplishment
- Limit TV/computer time to 2 hours/day
- Pregnancy/STI prevention
- Self-breast/testicular exam
- Develop a family plan for exiting house in a fire/establish meeting place after exit
- Discuss drug/tobacco/alcohol use and peer pressure
- Discuss family expectations concerning dating/sexual contact/abstinence/substance use/peer pressure
- Do not ride in a car with teens who use alcohol/drugs
- During sports wear protective gear at all times
- Get to know teen's friends and their parents
- Lock up guns, enroll in gun safety class if interested
- Promote use of seat belt
- Provide home safety for fire/carbon monoxide poisoning
- Provide safe/quality/appropriate after-school care
- Teach self-safety if feeling unsafe at friend's home/car, answer the door/telephone when adult not home, personal body privacy
- Discuss additional help with teacher if there are concerns/bullying
- Discuss school activities and school work
- Provide space/time for homework/personal time

TB QUESTIONNAIRE Place a mark in the appropriate box: **Yes** **Do not know** **No**

Have you been tested for TB? If yes, when (date)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a positive Tuberculin Skin Test? If yes, when (date)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TB can cause fever that lasts for days or weeks, unexplained weight loss, a bad cough (lasting over two weeks), or coughing up blood. As far as you know:			
have you been around anyone with any of these symptoms or problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
have you been around anyone sick with TB?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
have you had any of these symptoms or problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Were you born in Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe, or Asia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you traveled in the past year to Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe, or Asia for longer than 3 weeks? If so, specify which country/countries?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
To your knowledge, have you spent time (longer than 3 weeks) with anyone who is/has been an intravenous (IV) drug user, HIV-infected, in jail or prison, or has recently come to the United States from another country?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>