

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: \_\_\_\_\_

Sexually Active: Y  N

Last Menstrual Period: \_\_\_\_\_  
 Menstrual Cycle # Days: \_\_\_\_\_

Current Medications: \_\_\_\_\_  
 If sexually active using contraception: Y  N

Visits to other health-care providers, facilities: \_\_\_\_\_

Parental concerns/changes/stressors in family or home: \_\_\_\_\_

Psychosocial/Behavioral Health Issues: Y  N   
 Findings: \_\_\_\_\_

**DEVELOPMENTAL/MENTAL HEALTH SCREENING:**

Use of standardized tool (required once 12-18 years):

PSC-17 PSC-35 Y-PSC PHQ-9 CRAFFT

P F Findings: \_\_\_\_\_

**TUBERCULOSIS:**

TB questionnaire\*, risk identified: Y  N

\**Tuberculin Skin Test if indicated* TST

(TB questionnaire-Page 2)

**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  Td/Tdap  
 Meningococcal  MMR  Pneumococcal\*  
 Varicella  Influenza

\*Special populations: See ACIP

**LABORATORY**

Tests ordered today:  
 HIV (required once 16-18 year)

Other: \_\_\_\_\_

Signature/title \_\_\_\_\_

**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

**SENSORY SCREENING:**

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 \_\_\_\_\_

Name:

Medicaid ID:

**Typical Developmentally Appropriate Health Education Topics**

**17 Year Old Checkup**

- Provide nutritious meals and snacks; limit sweets/sodas/high-fat foods
- Discuss family expectations concerning dating/sexual contact/abstinence/substance use/peer pressure
- 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
- Promote healthy weight
- Self-breast/testicular exam
- Discuss self-safety in stalking/abusive relationship/bullying
- Do not ride in a car if use of alcohol/drugs involved
- 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 information about sexuality/risks involved in sexual activity
- Teach self-safety at friend's home/car and how to exit situation
- Discuss additional help with teacher if there are concerns/bullying
- Discuss nonviolent conflict resolution, demonstrate anger management at home
- Discuss school activities and school work
- Encourage independent decision-making skills/thinking through steps of a project/encourage involvement in family decisions
- Establish an agreed-on curfew, after-school activities
- Establish self-responsibility for homework completion
- Observe for signs of depression/anxiety or other mental health issues
- Provide space/time for homework/personal time
- Discuss tobacco use

<b>TB QUESTIONNAIRE</b> 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"/>