

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:

Concerns/changes/stressors in family or home:

Psychosocial/Behavioral Health Issues: Y  N

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  Td/Tdap  
 Meningococcal  MMR  Pneumococcal\*  
 Varicella  Influenza

\*Special populations: See ACIP

**LABORATORY**

Tests ordered today:

Dyslipidemia Screening (required once 18-20 years)

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

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**

**19 Year Old Checkup**

- Eat nutritious meals and snacks; limit sweets/sodas/high-fat foods
- Avoid alcohol/drugs/tobacco/steroid use
- Engage in physical activity for 1 hour/day
- Focus on healthy weight
- Manage conflict resolution in constructive/nonviolent manner
- Pregnancy/STI prevention
- Recognize signs of depression/anxiety or other mental health issues and discuss with parents/trusted adult/doctor if needed
- Self-breast/testicular exam
- Before becoming sexually active, obtain information on protection against STDs/pregnancy
- Enroll in gun safety class if interested
- Lock up guns for safety of others in household
- No riding in a car if use of alcohol/drugs involved
- Self-safety in stalking/abusive relationship/bullying
- Use seat belt for self at all times and all others in the car when driving
- Adhere to agreed-on curfew, after-school/work activities
- Attend school/work on time
- Continue chores as participant in family support
- Make decisions about education/work training with help of family
- Practice independent decision skills/problem solving, making decision to engage in sexual activity
- Signing consents for health/legal matters
- Stay connected with family and discuss questions/fears with them as needed
- Transition to adulthood for health, social and work matters

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"/>