

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: _____

☐ 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: _____

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

16 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

TB QUESTIONNAIRE Place a mark in the appropriate box:

	Yes	Do not know	No
Have you been tested for TB?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, when (date)			
Have you ever had a positive Tuberculin Skin Test?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, when (date)			
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If so, specify which country/countries?			
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"/>