

Name \_\_\_\_\_  
 Date of Birth \_\_\_\_\_  
 Chart No. \_\_\_\_\_

## 10-11 Year Female

Date \_\_\_\_\_ Time \_\_\_\_\_

**Actual Age** \_\_\_\_\_ **Weight** \_\_\_\_\_ lb \_\_\_\_\_ oz. **Height** \_\_\_\_\_ in. **BMI** \_\_\_\_\_

**Temp** \_\_\_\_\_ **Pulse** \_\_\_\_\_ **Resp** \_\_\_\_\_ **BP** \_\_\_\_\_ **Pain Score (0 - 5)** \_\_\_\_\_

Environmental Screen  Growth chart plotted

Nutrition:  Vitamins  Fluoride

Adverse Reactions (drug allergies):  Yes\* \_\_\_\_\_  No \*If yes, also list on Patient Problem Summary in front of chart.

Parent section reviewed?  Parent's concerns addressed

Immunizations current (copy in chart)  Off Schedule  Parental Refusal Explain \_\_\_\_\_

Problems: \_\_\_\_\_

For patients over the age of 6, do they feel safe at home?  Yes  No

**Current Medications:**  None or list medications below.

Name	Dose	Frequency

Nurse's Signature

X

**Physical:** Check (☑) if normal. Circle if abnormal and describe.

General Appearance

Head/Face/Neck

Eyes

ENMT

Respiratory

Chest

CV

Abdomen

Genitalia

Skin

Lymph nodes

Extremities

Musculoskeletal

Back

Neuro

Psych

Suicide Risk Assessment

**Anticipatory Guidance:**  School  Nutrition  Tobacco  Alcohol  Initiated PSC-17  Guns/trigger locks

Car Safety  Drugs  Educational handouts  Medication Education (if applicable)  Immunizations  Sex Education

**Assessment:** Menarche  Yes  No Age \_\_\_\_\_ LMP \_\_\_\_\_

**Plan:**  Tdap  MCV4  HPV  Flu  Hgb or CBC (If necessary \_\_\_\_\_ value)  Counseled

Urine Screen (if necessary)  UTO  WNL

Hearing Objective: Pass \_\_\_\_\_ Fail \_\_\_\_\_  Vision Objective: Right \_\_\_\_\_ Left \_\_\_\_\_  Glasses/contacts

Color Perception (if necessary) Pass \_\_\_ Fail \_\_\_

Other \_\_\_\_\_

Interpretive Conference Conducted Return \_\_\_\_\_

Parent/guardian instructed to keep **Current Medication List** to share with other providers and for emergencies. **INITIALS** \_\_\_\_\_

Parent/guardian verbalized understanding the **Plan of Care**. **INITIALS** \_\_\_\_\_

Physician/Practitioner's Signature

X

Date

/ /

Time

AM/PM

:

## Parent/Patient Section 10-11 Year Female

### SECTION TO BE COMPLETED BY PARENT

**Personal/Social History**

*Are you **CONCERNED** about your child's...*

(check appropriate box for each question)

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 1. Overall progress in school?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Happiness, self esteem, self confidence?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Ability to sit still, listen or participate?                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. School attendance?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Physical development?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Social development (lack of friends, excessive shyness, withdrawal from family)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Behavioral development (temper outbursts, aggression, violence)?                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Emotional development (mood changes, anxiety, depression) ?                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Eating habits, weight loss, loss of energy, sleep habits?                        | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Recurrent ear, sinus or throat infections, nosebleeds?                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Chest pain, shortness of breath, or irregular heartbeat?                        | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Frequent colds, cough, wheezing, recurrent bronchitis?                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Abdominal pain, vomiting, diarrhea, constipation?                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Urinary control, bed wetting, urinary infections?                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Joint pain, stiffness, swelling, muscle pain, weakness?                         | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Birthmarks, skin rashes, itching, nail or hair problems?                        | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Recurrent headaches, dizziness, tics, weak, seizures?                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Mood changes, sadness, nervous problems?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Excessive thirst or hunger, increased urination, weight loss?                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Paleness, anemia, easy bruising, swollen glands?                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Milk, food or drug allergies, recurrent infections?                             | <input type="checkbox"/> | <input type="checkbox"/> |

**Environmental Screening**

*Does your child....*

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 22. Exercise on a regular basis?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Use a helmet skating and biking?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Use a seat belt, ride in the back?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Do you counsel her about avoiding the use of alcohol, tobacco, drugs and inhalants? | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Are there guns in the house?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Does anyone in the household smoke?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Do you have a swimming pool?  | <input type="checkbox"/> | <input type="checkbox"/> |

**History Update**

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 29. Has there been a change in your child's medical history?        | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Has there been a change in your child's family medical history? | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Change in household situation?                                  | <input type="checkbox"/> | <input type="checkbox"/> |

**Parent Comments (Please Print)**

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other<br>32. Do you have any concerns you wish to discuss? | <input type="checkbox"/> | <input type="checkbox"/> |

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Signature

**X**

Date MM/DD/YY

/ /

Time 00:00 AM/PM

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