

Date _____ Patient # _____

Name _____ Date of Birth _____

Address _____
_____Lives with: 1 parent 2 parents Other caregiver Others (including siblings) _____May release information to: (parent, guardian, other family -- list) _____

Strengths: _____

Parental concerns: _____

Changes in child's health since last visit: _____
_____**GENERAL HEALTH:****Nutrition/Dental:**

YES NO

- Eat 3 meals/day, including breakfast?
 4 servings of low-fat dairy?
 Juice/pop/soda? _____ a day
 Fruits and vegetables every day?
 Family meals?
 Brush/floss teeth?
 Has twice yearly dental visit?
 Exercises an hour most days?

Sleep: _____ hours through the night

Problems? YES NO _____If female: Menarche? Yes No When _____Menses: Regular IrregularBleeding: Normal HeavyCramps: Yes Normal Severe

LMP: _____

DEVELOPMENT:

School: Grade _____ @ _____ School

Problems: YES NO _____

Activities: _____

Positive HEADSS questions were discussed YES NOPeer relations: Good Concerns: _____Mood: Positive Concerns: _____**MEDICAL HISTORY:**

Medications/supplements: _____

Allergies: _____

Major medical illnesses: _____

Hospitalizations _____

Surgeries: _____

FAMILY HISTORY: Reviewed and updated**SOCIAL HISTORY:****FAMILY RISK FACTORS:**

Changes in family since last visit: _____

Stress: How much stress are you and your family under now? None Slight Moderate Severe**What kind of stress?** Relationships Drugs Alcohol Violence/Abuse Academic Financial Health Insurance Other _____**How stressful is caring for your adolescent?** None Slight Moderate Severe**MATERNAL/CAREGIVER DEPRESSION:**In the past month, have you/partner felt down, depressed or hopeless? No Sometimes OftenIn the past month have you/partner felt little interest or pleasure in doing things? No Sometimes Often**ANTICIPATORY GUIDANCE:** Check only if discussed**FAMILY FUNCTIONING:**

- Media limitation, monitor content; NO TV or computer in bedroom
 Clearly state rules/expectations/responsibilities, Consistently follow through with consequences
 Family meals, positive attention

NUTRITION / OBESITY PREVENTION / ORAL HEALTH:

- Limit junk food-have healthy snacks, fruits/vegetables, calcium
 1 hr exercise a day
 Dental hygiene-brushing, flossing BID, exams every 6 months

BEHAVIOR & DEVELOPMENT :

- Praise positive activities/achievements, not appearance
 LISTEN, RESPECT adolescent's concerns, opinions, privacy;
 Help with organization / priority setting, dealing with stress
 Actively discuss delaying sexual behavior; dating, curfew
 Discuss avoidance of alcohol, tobacco, inhalants, other drugs; express your values
 Supervise – anticipate errors in judgment, increased risk-taking

SAFETY:

- Know your adolescent's friends and their parents. Discuss what to do if feel unsafe
 ALWAYS wear seatbelt; helmet with wheels!
 Sunscreen; no tanning salons
 Water safety –swim always with someone else, life jacket in boat; protective sports gear
 Gun safety (including b.b. guns)
 Avoid loud noises, especially music from earphones
 Find ways to deal with stress, conflict – seek professional help if frequently sad, anxious, or if thinking of hurting yourself.
 Substance avoidance; including binge drinking. Designated driver
 Healthy relationships based on respect, mutual interests. Saying "No" is OK. Sexual safety, safety in relationships

PHYSICAL EXAMINATION

Vital signs: P: _____ R: _____ T: _____ BP _____ / _____ Weight _____ (_____ %) Height _____ (_____ %)

BMI _____ (_____ %) Vision screening: R 20/ _____ L 20/ _____ Hearing: R _____ L _____

N Abn*Comment on abnormal findings*

General appearance _____

Behavior/interaction with family _____

Skin _____

Head/scalp _____

Ears _____

Eyes _____

Nose _____

Mouth/Throat _____

Teeth _____

Neck _____

Back/Chest _____

Lungs _____

Heart _____

Abdomen _____

Genitalia _____

Sexual Maturity Stage ____ breast (female) ____ genitals (male) ____ pubic hair (female & male)

Musculoskeletal _____

Neurologic _____

Results reviewed: (outside info, lab, etc.) _____

Impression: _____

PLAN OF CARE (see Anticipatory Guidance)**Immunizations:**

Vaccine Information Statements offered to parent

Past adverse reactions to immunizations: No Yes _____

See **current guidelines** www.immunize.org/aap

LAB: if indicated _____

Referral: (if indicated) _____

Central referral numbers: For assistance with care coordination, transportation, or health information for children **birth through age 21:**
Healthy Families Line 1-800-369-2229

For referral of children with developmental delay or educational concerns **3 yr through high school:**
local **Iowa Area Education Agency** www.iowaaea.org

Handouts: _____

Return appointment: _____

Signature _____ Date _____