Iowa Child Health and Development Record — 11-17 year Well Exam

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 ❑ Irregular

Bleeding: ❑ Normal ❑ Heavy

Cramps: ❑ Yes ❑ Normal ❑ Severe

LMP:_____

DEVELOPMENT:

School: Grade_____@_____School

Problems: ❑ YES ❑ NO_____

Activities:_____

Positive HEADSS questions were discussed ❑ YES ❑ NO

Peer relations: ❑ Good ❑ Concerns:_____

_____

Mood: ❑ Positive ❑ Concerns:_____

_____

MEDICAL HISTORY:

Medications/supplements:_____

Allergies:_____

Major medical illnesses:_____

_____

Hospitalizations_____

_____

Surgeries:_____

Adolescent Screen: PHQ2, CRAFFT

Over the past 2 weeks, how often have you been bothered by any of the following problems:

Little interest or pleasure in doing things

❑ Not at all ❑ Several days ❑ More than half the days ❑ Nearly every day

Feeling down, depressed or hopeless

❑ Not at all ❑ Several days ❑ More than half the days ❑ Nearly every day

During the PAST 12 MONTHS, did you:

A1. Drink any alcohol (more than a few sips)? ❑ No ❑ Yes

A2. Smoke any marijuana or hashish? ❑ No ❑ Yes

A3. Use anything else to get high? ❑ No ❑ Yes

If you answered NO to ALL (A1, A2, A3**), answer only B1 then stop.**

If you answered YES to ANY (A1, A2, A3**) answer B1 to B6 below.**

B1. Have you ever ridden in a CAR driven by someone (including yourself) who was high or had been using alcohol or drugs? ❑ No ❑ Yes

B2. Do you ever use alcohol or drugs to RELAX, feel better about yourself or fit in? ❑ No ❑ Yes

B3. Do you ever use alcohol or drugs while you are by yourself or ALONE? ❑ No ❑ Yes

B4. Do you ever FORGET things you did while using alcohol or drugs? ❑ No ❑ Yes

B5. Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use? ❑ No ❑ Yes

B6. Have you ever gotten into TROUBLE while you were using alcohol or drugs? ❑ No ❑ Yes

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

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PHYSICAL EXAMINATION

Vital signs: P: _____R: _____T: _____ BP_____/_____Weight_____(_____%) Height_____(_____%)

BMI_____ (_____%) Vision screening: R 20/_____L 20/_____ Hearing: R_____L_____ (subjective test)

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 _____

❑ ❑ Other Screening ❑ PHQ-9 ❑ CRAFFT part 2 ❑ other _____

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: ❑ HIV screening once if sexually active ❑ STD screen, GC chlamydia if sexually active ❑ TB: Assess risk

❑ Lipid screening once between 18-20, assess risk other ages ❑ Hb or Hct: Assess risk ❑ other 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 _____