

Name				Accompanied by	
Date	MRN	Date of Birth	Sex <input type="radio"/> M <input type="radio"/> F	Preferred Language	

ATTACH LABEL

**PATIENT OR CAREGIVER CONCERNS/INTERVAL HISTORY**

None

- PAST MEDICAL HISTORY**  Reviewed and updated
- SURGICAL HISTORY**  Reviewed and updated
- FAMILY HISTORY**  Reviewed and updated
- MEDICATIONS**  None  
 Reviewed and updated
- ALLERGIES**  No known drug allergies  
 \_\_\_\_\_

- Nutrition:**  Varied diet, including fruits & vegetables  
\_\_\_\_\_
- Iron-rich food  Yes  No \_\_\_\_\_
- Milk \_\_\_\_\_ (three servings per day)  
 whole  2%  skim  other \_\_\_\_\_
- Water \_\_\_\_\_
- Juice \_\_\_\_\_ oz/day
- Other liquids \_\_\_\_\_

- Dental:**  Twice daily oral health care \_\_\_\_\_  
 Has had twice yearly dental visit \_\_\_\_\_  
 Fluoride in water at home \_\_\_\_\_

- Menstrual History**
- Age of onset \_\_\_\_\_  N/A \_\_\_\_\_
- Regular, Irregular  Excessive pain
- Heavy period

- Elimination:** YES NO
- Soft, easy to pass BMs \_\_\_\_\_
- Issues with constipation \_\_\_\_\_
- Normal urine stream \_\_\_\_\_
- Voiding concerns \_\_\_\_\_

- Sleep:** Total sleep hours \_\_\_\_\_
- Snoring  
 occasional  
 more than three days/week  
(high risk for sleep apnea)
- Sleep concerns  Yes  No

## Risk Assessment

- |                       |                       |                                      |
|-----------------------|-----------------------|--------------------------------------|
| <b>HIGH</b>           | <b>LOW</b>            |                                      |
| <input type="radio"/> | <input type="radio"/> | TB _____                             |
| <input type="radio"/> | <input type="radio"/> | Anemia _____                         |
| <input type="radio"/> | <input type="radio"/> | Dyslipidemia _____                   |
| <input type="radio"/> | <input type="radio"/> | STI _____                            |
| <input type="radio"/> | <input type="radio"/> | Tobacco, alcohol, and drug use _____ |

## DEVELOPMENT

- |                       |                       |   |
|-----------------------|-----------------------|---|
| <b>YES</b>            | <b>NO</b>             |   |
| <input type="radio"/> | <input type="radio"/> | Able to bounce back from disappointment |
| <input type="radio"/> | <input type="radio"/> | Chores or responsibilities at home      |
| <input type="radio"/> | <input type="radio"/> | Clear rules and expectations at home    |
| <input type="radio"/> | <input type="radio"/> | Ability to get along with others        |
| <input type="radio"/> | <input type="radio"/> | Controls emotions                       |
| <input type="radio"/> | <input type="radio"/> | Frequently has worries                  |

Caregiver concerns about development and behavior:

## SCHOOL

- School Grade: \_\_\_\_\_ Favorite subject/activity: \_\_\_\_\_
- Concerns about school experience:  Yes  No \_\_\_\_\_
- Extra education services through the school:  Yes  No \_\_\_\_\_
- Activities outside of school: \_\_\_\_\_
- Peer relations:  Good  Okay  Poor

## SOCIAL HISTORY

- Reviewed and updated
- Lives with:  1 parent  2 parents  Other caregiver

Others (including siblings):

## FAMILY RISK FACTORS:

Changes in family since last visit:

## Do you need additional assistance with any of the following?

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Getting enough to eat | <input type="checkbox"/> Relationships | <input type="checkbox"/> Drug abuse    |
| <input type="checkbox"/> Violence/Abuse        | <input type="checkbox"/> Financial     | <input type="checkbox"/> Alcohol abuse |
| <input type="checkbox"/> Health Insurance      | <input type="checkbox"/> Child care    |  |
| <input type="checkbox"/> Other _____           |  |  |

## PHQ2 Depression Screening:

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

- 0-Not at all 1-Several days  
2-More than half the days 3-Nearly every day

Little interest or pleasure in doing things 0 1 2 3

Feeling down, depressed, or hopeless 0 1 2 3

Total score \_\_\_\_\_

**For scores 3 or over please complete PHQ9**

**PHYSICAL EXAMINATION**

Height _____ cm (____%ile)	Weight _____ Kg (____%ile)		BMI _____ kg/m2 (____%ile)	
<b>VITALS:</b>	Temp: _____	BP ____/____	HR: _____	Resp Rate: _____ SpO2 _____
Hearing Screen:	Left: (pass/fail)	Right: (pass/fail)		
Vision Screen:	Left: _____	Right: _____	Bilateral: _____	

**Normal examination findings are listed below. Describe other findings in the area provided.**

**General:** Well appearing, active, and alert. \_\_\_\_\_

**Head:** Normocephalic and atraumatic. \_\_\_\_\_

**Eyes:** Red reflex, present bilaterally. Pupils equal, round, and reactive to light. No discharge. \_\_\_\_\_

**ENT:** No ear deformities. Normal external canals. Tympanic membranes clear bilaterally. Nares patent. \_\_\_\_\_

**Mouth:** No oral lesions. Normal dentition. \_\_\_\_\_

**Neck:** Supple, with full range of motion. \_\_\_\_\_

**Cardiovascular:** Regular rate and rhythm. Heart sounds S1, S2 normal. No murmur. \_\_\_\_\_

**Chest:** No increased work of breathing. Clear and symmetric breath sounds bilaterally. \_\_\_\_\_

**Abdomen:** Soft, non-distended, no masses, no hepatosplenomegaly. \_\_\_\_\_

**Genitourinary:**

Normal female external genitalia. \_\_\_\_\_

Normal male external genitalia. Testes descended bilaterally, no scrotal swelling, no inguinal hernia \_\_\_\_\_

**Sexual Maturity Rating (Tanner Staging):**

Female: Breast development \_\_\_\_\_, pubic hair \_\_\_\_\_

Male: Testicular development \_\_\_\_\_, pubic hair \_\_\_\_\_

**Musculoskeletal:** Spine normal, symmetric gluteal folds. Moves all extremities symmetrically. \_\_\_\_\_

**Neurological:** Normal strength and tone. \_\_\_\_\_

**Skin:** Normal color. No lesions. \_\_\_\_\_

Other comments:

ATTACH LABEL

**ANTICIPATORY GUIDANCE**

**SOCIAL DETERMINANTS OF HEALTH:**

- Interpersonal violence
- Living situation and food security
- Family substance use
- Connectedness with family, peers, and community
- School performance
- Coping with stress and decision-making

**FAMILY FUNCTIONING:**

- Media limitation, monitor content
- Clearly state rules/expectations/responsibilities, Consistently follow through with consequences
- Patience and control over anger
- Family meals, positive attention

**EMOTIONAL WELL-BEING:**

- Mood regulation and mental health
- Sexuality

**RISK REDUCTION:**

- Pregnancy and sexually transmitted infections
- Tobacco, e-cigarettes, alcohol, and prescription or street drugs
- Know about your child's Internet use, implement rules for the Internet, and install safety filters
- Avoid loud music through headphones/ear buds

**SAFETY:**

- Seat belt and helmet use
- Sun protection
- Substance use and riding in a vehicle
- Firearm safety

**FAMILY NUTRITION/OBESITY PREVENTION/ORAL HEALTH:**

- Dental hygiene-daily brushing, flossing, regular exams
- Body image
- Healthy eating- fruits, vegetables, calcium
- Limit junk food-have healthy snacks
- Physical activity and sleep

**BEHAVIOR:**

- 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

**ASSESSMENT**

**Well Adolescent Exam**

- Normal BMI percentile for age \_\_\_\_\_
- Normal BP for age \_\_\_\_\_

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

**Immunizations:**

- Vaccine Information Statements Given
- Vaccine counseling given
- Vaccines due:  HPV  MenACWY  MenB (for patients at prolonged increased risk)  Tdap
- If indicated:**  Influenza  COVID-19
- Catch-up vaccinations given
  - Hep A  Polio
  - Hep B  Tdap
  - MMR  Varicella

High risk:  PPSV23

Past adverse reactions to immunizations:

- No  Yes \_\_\_\_\_

**See current guidelines:** <https://www.cdc.gov/vaccines/index.html>

**Preparticipation physical exam and cardiac screening**  
(refer to sports physical form for details)

- completed  not completed

**Lipid Screening** (Universal lipid screening once between 17-21)

**HIV Screening** (Universal HIV screening once between 15-18)

- LAB if high risk:**  HIV  Lipid Panel  Hb or Hct  
 Sexually transmitted infections  TB  
 other \_\_\_\_\_

**Area Education Agencies:** For development or educational concerns contact your local AEA. <http://www.iowaaea.org/>

**5-2-1-0:** Healthy choices framework. For more information: [iowahealthieststate.com/resources/individuals/5210/](http://iowahealthieststate.com/resources/individuals/5210/)

**Healthy Families Line:** For assistance with care coordination, transportation, or health information for children birth through age 21 call (800)369-2229

**Return appointment:**

- Follow-up in 12 months \_\_\_\_\_
- Other/referral based on risk assessment \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

ATTACH LABEL

**NOTES**

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