

**PEDIATRIC VISIT 11 TO 13 YEARS**

DATE OF SERVICE \_\_\_\_\_

NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

AGE \_\_\_\_\_

WEIGHT \_\_\_\_\_ / \_\_\_\_\_ % HEIGHT \_\_\_\_\_ / \_\_\_\_\_ % TEMP \_\_\_\_\_ BP \_\_\_\_\_

**HISTORY REVIEW/UPDATE:** *(note changes)*

Family health history \_\_\_\_\_

Medical history \_\_\_\_\_

**PSYCHOSOCIAL ASSESSMENT:**

Recent changes in family?: *(circle all that apply)*

New members, separation, chronic illness, death, recent move,  
Loss of job, other \_\_\_\_\_

Violence Assessment *(interview separately):*

Any fears of partner/other violence? No \_\_\_\_\_ Yes \_\_\_\_\_

Access to gun/weapon? No \_\_\_\_\_ Yes \_\_\_\_\_

**SUBSTANCE ABUSE ASSESSMENT:**

Neg: \_\_\_\_\_ Pos: \_\_\_\_\_ For: \_\_\_\_\_

Referral: \_\_\_\_\_ No \_\_\_\_\_ Yes \_\_\_\_\_ To: \_\_\_\_\_

**RISK ASSESSMENT: CHOL TB STD/HIV**

(Circle) Pos/Neg Pos/Neg Pos/Neg

**MENTAL HEALTH ASSESSMENT:**

Problem identified? \_\_\_\_\_No \_\_\_\_\_Yes

Referral? \_\_\_\_\_No \_\_\_\_\_Yes To: \_\_\_\_\_

**PHYSICAL EXAMINATION**

- |                          |                          |                                   |
|--------------------------|--------------------------|-----------------------------------|
| Wnl                      | Abn                      | (describe abnormalities)          |
| <input type="checkbox"/> | <input type="checkbox"/> | Appearance/Interaction            |
| <input type="checkbox"/> | <input type="checkbox"/> | Growth (S/S of eating disorders?) |
| <input type="checkbox"/> | <input type="checkbox"/> | _____                             |
| <input type="checkbox"/> | <input type="checkbox"/> | Skin                              |
| <input type="checkbox"/> | <input type="checkbox"/> | _____                             |
| <input type="checkbox"/> | <input type="checkbox"/> | Head/Face                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Eyes/Red reflex                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Cover test/Eye muscles            |
| <input type="checkbox"/> | <input type="checkbox"/> | Ears                              |
| <input type="checkbox"/> | <input type="checkbox"/> | Nose/Mouth/Dental                 |
| <input type="checkbox"/> | <input type="checkbox"/> | _____                             |
| <input type="checkbox"/> | <input type="checkbox"/> | Neck/Nodes                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Lungs                             |
| <input type="checkbox"/> | <input type="checkbox"/> | _____                             |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart/Pulses                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest/Breasts                     |
| <input type="checkbox"/> | <input type="checkbox"/> | _____                             |
| <input type="checkbox"/> | <input type="checkbox"/> | Abdomen                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Genitals/TannerStage/Pelvic/GU    |
|                          |                          | Age at menarche _____ LMP _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Musculoskeletal                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Neuro/Reflexes                    |
| <input type="checkbox"/> | <input type="checkbox"/> | _____                             |
| <input type="checkbox"/> | <input type="checkbox"/> | Vision (gross assessment)         |
| <input type="checkbox"/> | <input type="checkbox"/> | Hearing (gross assessment)        |
|                          |                          | _____                             |

**NUTRITIONAL ASSESSMENT:**

Typical diet:

Physical Activity:

Education: Choose variety of foods \_\_\_\_\_ Sociable at table \_\_\_\_\_

Avoid fad diets/eating disorders \_\_\_\_\_ Select healthy  
snacks \_\_\_\_\_

**DEVELOPMENTAL ASSESSMENT:**

Name of School:

Grade:

Performance:

Peer Relations:

Family Relations:

Extracurricular activities:

Misc. issues:

**ANTICIPATORY GUIDANCE:**

Social: Family and peer activities \_\_\_\_\_ Ownership and  
competition \_\_\_\_\_ Responsibility for self and family \_\_\_\_\_

Parenting: Establish fair, negotiable rules \_\_\_\_\_ Allow decisions \_\_\_\_\_

Money, allowance \_\_\_\_\_ Promote mutual & self-respect \_\_\_\_\_

Respect privacy \_\_\_\_\_ Spend time with child talking,  
projects \_\_\_\_\_

Play and communication: Organized sports \_\_\_\_\_ Monitor TV  
use \_\_\_\_\_

Health: Dental care \_\_\_\_\_ Personal hygiene \_\_\_\_\_ Smoking \_\_\_\_\_

Second hand smoke \_\_\_\_\_ Fluoride \_\_\_\_\_ Use sunscreen \_\_\_\_\_

Tick prevention \_\_\_\_\_

Sexuality: Prepare for physical changes \_\_\_\_\_ Masturbation \_\_\_\_\_

Modesty \_\_\_\_\_ Sexual Responsibility \_\_\_\_\_ STDs \_\_\_\_\_

Injury prevention: Seat belt \_\_\_\_\_ Rear seat until age 12 \_\_\_\_\_

Bicycle helmet \_\_\_\_\_ Riding in traffic \_\_\_\_\_ Smoke detector/  
escape plan \_\_\_\_\_ Poison control no. \_\_\_\_\_

Firearms (toys; owner risk/safe storage) \_\_\_\_\_ Protective  
devices in sports \_\_\_\_\_ Water safety \_\_\_\_\_

**PLANS**

1. Review immunizations and bring up to date.
2. PPD if risk assessment is positive
3. Dental visit advised \_\_\_\_\_ or date of last visit \_\_\_\_\_
4. Objective Hearing and Vision Tests recommended
5. Testing/counseling if positive cholesterol risk assessment.
6. Testing if positive STD/HIV risk assessment
7. Check original metabolic results; offer testing for sickle cell trait if results are not available.
8. Return visit \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Signatures \_\_\_\_\_