

**PEDIATRIC VISIT 14 TO 16 YEARS**

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

NAME \_\_\_\_\_ M / F DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_

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

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

Medical history updated? Yes / No \_\_\_\_\_

Family health history updated? Yes / No \_\_\_\_\_

Reactions to immunizations? Yes / No \_\_\_\_\_

Concerns: \_\_\_\_\_

**PSYCHOSOCIAL ASSESSMENT:**

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

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

Environment: Smokers in home? Yes / No

Violence Assessment: *(interview separately)*

Any fears of partner/other violence? Yes / No

Access to gun/weapon? Yes / No

**SUBSTANCE ABUSE ASSESS/SCREENING:**

Pos / Neg For: \_\_\_\_\_ Counseled? Yes / No

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

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

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

**MENTAL HEALTH ASSESSMENT:**

Problem identified? Yes / No \_\_\_\_\_

Counseling provided? Yes / No \_\_\_\_\_

Referral? Yes / No To: \_\_\_\_\_

**PHYSICAL EXAMINATION**

- |                          |                          |  |
|--------------------------|--------------------------|--|
| Wnl                      | Abn                      | <i>(describe abnormalities)</i>        |
| <input type="checkbox"/> | <input type="checkbox"/> | Appearance/Interaction                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Growth (symptoms of eating disorders?) |
| <input type="checkbox"/> | <input type="checkbox"/> | _____                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Skin                                   |
| <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                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Mouth/Gums/Dentition                   |
| <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/Tanner Stage/Pelvic/GU        |
| <input type="checkbox"/> | <input type="checkbox"/> | 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 <i>(gross assessment)</i>       |
| <input type="checkbox"/> | <input type="checkbox"/> | Hearing <i>(gross assessment)</i>      |

**Nutritional Assessment:**

Typical diet *(specify foods):*

Symptoms of eating disorder? Yes / No

**Physical Activities:**

At least 1hr. exercise daily? Yes / No

Education: Food sources of iron, calcium, folic acid

Select healthy foods  Prevent obesity  Eat breakfast

Avoid eating disorders/fad diets  2 hrs or less of TV/computer games

5 fruits/vegetables daily  No sweetened beverages

**DEVELOPMENTAL SURVEILLANCE:**

Name of School: Grade: \_\_\_\_\_ Performance: \_\_\_\_\_

Peer Relations:

Family Relations:

Extracurricular activities:

Misc. issues:

**ANTICIPATORY GUIDANCE:**

Social: Confidentiality  Peer group pressures  Mood swings

Dependence vs. independence  Establishing own values

Social misconduct due to family dysfunctions  Future plans

Stay in school  Love life  ETOH use  Drug Abuse

Parenting: Establish fair, negotiable rules  Allow decisions

Provide support, encouragement  Money, allowance

Promote mutual respect  Respect privacy

Health: Dental care  Personal hygiene  Fluoride  Menstruation

Breast/testicular self-exam  Smoking  Second hand smoke  Use

sunscreen  Tick prevention

Sexuality: Prepare for physical changes  Birth control  STDs

Sexual Responsibility

Injury prevention: Seat belt  Alcohol/drug use  Bicycle helmets

Protective devices in sports  Water safety

Smoke detector/escape plan  Firearms (owner risk/safe storage)

**PLANS/ORDERS/REFERRALS**

1. Review immunizations and bring up to date  \_\_\_\_\_
2. PPD, if positive risk assessment  \_\_\_\_\_
3. Recommend Objective Hearing and Vision Tests  \_\_\_\_\_
4. Testing/counseling if positive cholesterol risk assessment  \_\_\_\_\_
5. Testing if positive STD/HIV risk assessment  \_\_\_\_\_
6. Dental visit advised  or date of last visit \_\_\_\_\_
7. Next preventive appointment at \_\_\_\_\_
8. Referrals for identified problems: Yes / No *(specify)*

Signatures: \_\_\_\_\_