

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Current Medications			Drug / Food Allergies		Accompanied By		
Age <input type="checkbox"/> M <input type="checkbox"/> F	Ht.	Wt.	BMI and %ile	B/P	HR	Temp	Interpreter: Y / N
<b>Past Medical History</b>			<b>Risk Assessment/ HEEADSSS</b>				
Recent illness / injury: <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Child has a dental home: <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Last dentist visit : _____ Menarche: Age _____ Regular: <input type="checkbox"/> Yes <input type="checkbox"/> No _____			<b>HOME</b> Lives with: _____ Parent/teen interaction: <input type="checkbox"/> NL _____ Family meals: <input type="checkbox"/> Yes <input type="checkbox"/> No Has family / adult can turn to for help: <input type="checkbox"/> Yes <input type="checkbox"/> No <b>EDUCATION</b> Grade Level: _____ Performance: <input type="checkbox"/> NL _____ Future plans: <input type="checkbox"/> Yes <input type="checkbox"/> No <b>EATING</b> Balanced diet: <input type="checkbox"/> Yes <input type="checkbox"/> No Calcium: <input type="checkbox"/> Yes <input type="checkbox"/> No Sugary drinks: <input type="checkbox"/> Yes <input type="checkbox"/> No Snack habits: <input type="checkbox"/> NL _____ Body image: <input type="checkbox"/> NL _____ <b>ACTIVITIES</b> Friends: <input type="checkbox"/> Yes <input type="checkbox"/> No Involved in community: <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Exercises >60 mins/day: <input type="checkbox"/> Yes <input type="checkbox"/> No Hobbies / sports: _____ <b>DRUGS (substance use / abuse)</b> Uses Tobacco / ETOH / Drugs: <input type="checkbox"/> Yes <input type="checkbox"/> No CRAFFT Screening: <input type="checkbox"/> N/A <input type="checkbox"/> NL <b>SAFETY</b> Dating violence: <input type="checkbox"/> Yes <input type="checkbox"/> No Seat belt: <input type="checkbox"/> Yes <input type="checkbox"/> No Tanning bed: <input type="checkbox"/> Yes <input type="checkbox"/> No Social media: <input type="checkbox"/> Yes <input type="checkbox"/> No Bullied / bullying: <input type="checkbox"/> Yes <input type="checkbox"/> No <b>SEX</b> Has had oral sex: <input type="checkbox"/> Yes <input type="checkbox"/> No Sexual intercourse: <input type="checkbox"/> Yes <input type="checkbox"/> No # partners: _____ Uses protection: <input type="checkbox"/> Yes <input type="checkbox"/> No Hx of STI: <input type="checkbox"/> Yes <input type="checkbox"/> No _____ <b>SUICIDE / MENTALHEALTH</b> Has self-confidence: <input type="checkbox"/> Yes <input type="checkbox"/> No Problems with sleep: <input type="checkbox"/> Yes <input type="checkbox"/> No Gets depressed / anxious: <input type="checkbox"/> Yes <input type="checkbox"/> No Thoughts of hurting self: <input type="checkbox"/> Yes <input type="checkbox"/> No PHQ-2: <input type="checkbox"/> NL _____ PHQ-9: <input type="checkbox"/> N/A Score: _____ Behavioral health referral: <input type="checkbox"/> N/A <input type="checkbox"/> Yes				
<b>Parent / Teen Concerns:</b>							
<b>Identified Risks:</b> <input type="checkbox"/> None _____ _____ _____ _____ _____							
<b>Physical Exam (checked <input type="checkbox"/> = normal)</b>				<b>Abnormal Findings</b>			
<input type="checkbox"/> <b>General</b> (Alert, NAD, +eye contact) <input type="checkbox"/> <b>Head</b> (No deformities, symmetric) <input type="checkbox"/> <b>Eyes</b> (PERRL, EOMI, + RR, lids NL, conjunctivae/sclera clear) <input type="checkbox"/> <b>Ears</b> (Canals clear, TMs normal, orients to sounds, voice) <input type="checkbox"/> <b>Nose</b> (Mucosa NL, septum NL, patent) <input type="checkbox"/> <b>Mouth/Throat</b> (MMM, lips NL, tongue NL no oral lesions, no erythema, thyroid NL) <input type="checkbox"/> <b>Teeth</b> (Gums NL, dentition NL, no staining, caries or white spots)				<input type="checkbox"/> <b>Heart</b> (No murmurs) <input type="checkbox"/> <b>Lungs</b> (Clear breath sounds) <input type="checkbox"/> <b>Abdomen</b> (Soft, non-tender, no masses) <input type="checkbox"/> <b>Skin</b> (No rashes, no lesions, no acne) <input type="checkbox"/> <b>Neuro</b> (Tone, symmetry, strength, & gait NL) <input type="checkbox"/> <b>Extremities</b> (Full ROM, strength/tone NL) <input type="checkbox"/> <b>Back</b> (No excessive curve) <input type="checkbox"/> <b>Genitalia</b> <i>Male</i> (Penis NL: circ/uncirc, no adhesions) <i>Female</i> (Labia/clitoris NL, no discharge) Tanner Stage: _____			
<b>Assessment</b>			<b>Anticipatory Guidance</b>				
<input type="checkbox"/> Well child <input type="checkbox"/> Normal growth and development <input type="checkbox"/> Transition readiness assessment <input type="checkbox"/> Immunizations UTD <input type="checkbox"/> IMMs due _____			<input type="checkbox"/> <b>Healthy Habits</b> (Brush teeth 2x/day, routine dentist visits, exercise daily, balanced diet, healthy snacks, limit screen time, adequate sleep) <input type="checkbox"/> <b>Safety</b> (Bullying, sport helmets/ protective gear, seat belts, safe dating, abstinence/protected sex, tanning salons, steroid use, no guns) <input type="checkbox"/> <b>Learning</b> (Help with homework, encourage school & community involvement, begin transition to an adult health care provider) <input type="checkbox"/> <b>Behavior</b> (Sexuality/puberty, respect limits and consequences, coping with stress, seek help if feeling depressed/anxious, build positive relationships)				
<b>Plan</b>							
<input type="checkbox"/> Vision acuity: R ___ / ___ L ___ / ___ Both ___ / ___ (12 yo) <input type="checkbox"/> Hearing screen: <input type="checkbox"/> NL _____ (1 screening between 11 yo and 14 yo) <input type="checkbox"/> Dental fluoride varnish every 3-6 mos. primary care or dental office <input type="checkbox"/> Fluoride supplementation risk assessment <input type="checkbox"/> TB testing based on risk factors			<input type="checkbox"/> Iron Deficiency Anemia risk assessment <input type="checkbox"/> Dyslipidemia risk assessment (12 yo and 13 yo) <input type="checkbox"/> Sexually transmitted infections (STI) risk assessment <input type="checkbox"/> Immunizations (See immunization record) <input type="checkbox"/> Update transition of care plan <input type="checkbox"/> Education handout given				

Next Appointment: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# Well Child Visit: 11-14 Years



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Notes:

Lined area for notes

Next Appointment: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_