

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? No _____ Yes _____
Access to gun/weapon? No Yes

SUBSTANCE ABUSE ASSESSMENT:
Neg: _____ Pos: _____ For: _____
Referral: No Yes To: _____

RISK ASSESSMENT: CHOL TB STI/HIV
(Circle) Pos / Neg Pos / Neg Pos / Neg

MENTAL HEALTH ASSESSMENT:
Problem identified? ___No ___Yes
Referral? ___No ___Yes To: _____
Counseling provided? No Yes

PHYSICAL EXAMINATION
Wnl Abn *(describe abnormalities)*
 Appearance/Interaction
 Growth (symptoms of eating disorders?)

 Skin
 Head/Face
 Eyes/Red reflex
 Cover test/Eye muscles
 Ears
 Nose
 Mouth/Gums/Dentition

 Neck/Nodes
 Lungs

 Heart/Pulses
 Chest/Breasts

 Abdomen
 Genitals/Tanner Stage/Pelvic/GU
Age at menarche _____ LMP _____
 Musculoskeletal
 Neuro/Reflexes

 Vision *(gross assessment)*
 Hearing *(gross assessment)*

NUTRITIONAL ASSESSMENT:
Typical diet *(specify foods):* _____

Physical Activities:
Education: Food sources of iron, calcium, folic acid
Select Healthy foods Prevent obesity
Avoid eating disorders/fad diets Eat breakfast

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 resulting from family dysfunctions
Future plans Stay in school Love life

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. Dental visit advised or date of last visit _____
 4. Recommend Objective Hearing and Vision Tests _____
 5. Testing/counseling if positive cholesterol risk assessment _____
 6. Testing if positive STD/HIV risk assessment _____
 7. Pap/UA if sexually active _____
 8. Next preventive appointment at _____
 9. Referrals for identified problems: Yes / No *(specify)*

Signatures: _____