

PEDIATRIC VISIT 17 TO 20 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: Select healthy foods Use skim milk/and lowfat foods
Obesity Avoid eating disorders/fad diets
Use of vitamin/mineral supplements, folic acid for females

DEVELOPMENTAL SURVEILLANCE:

Name of School: _____
Grade: _____ Performance: _____
Peer Relations: _____
Family Relations: _____
Extracurricular activities: _____
Misc. issues: _____

ANTICIPATORY GUIDANCE:

Social: Love life Peer groups pressures Mood swings
Social misconduct resulting from family dysfunctions
Establishing own values Future plans Stay in school
Parenting: Support Prepare for independence
Health: Dental care Fluoride Personal hygiene Smoking
Second hand smoke Menstruation Breast/testicular self-exam
Physical activity Use sunscreen Tick prevention
Sexuality: Birth control Sexual Responsibility STDs
Injury prevention: Seat belt Alcohol use Bicycle helmets
Protective devices in sports 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. Testing/counseling if positive cholesterol risk assessment _____
5. Testing if positive STD/HIV risk assessment _____
6. Pap/UA if sexually active _____
7. Next preventive appointment at _____
8. Referrals for identified problems: Yes / No *(specify)*

Signatures: _____