

PEDIATRIC VISIT 11 TO 14 YEARS

DATE OF SERVICE _____

NAME _____ M / F DATE OF BIRTH _____ AGE _____

WEIGHT _____ / _____ % HEIGHT _____ / _____ % BMI _____ / _____ % TEMP _____ BP _____

HISTORY REVIEW/UPDATE: (note changes)

Medical history updated? _____

Family health history updated? _____

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

RISK ASSESSMENT: (by questionnaire)

CHOL	TB	ANEMIA	STI/HIV
(Circle) Pos / Neg	Pos / Neg	Pos / Neg	Pos / Neg

SUBSTANCE USE Assessment:

CRAFTT/Other objective tool: Y/N _____

Tobacco	ETOH / DRUGS	e-Cigarettes/Vaping
Pos / Neg	Pos / Neg	Pos / Neg

Counseling provided? Yes/No _____

Referral/Testing? Yes/No

Specify: _____

MENTAL HEALTH ASSESSMENT:

PHQ-9 completed Yes/No _____

Problem identified? Yes / No _____

Counseling provided? Yes / No _____

Referral? Yes / No To: _____

PHYSICAL EXAMINATION: (unclothed)

Wnl	Abn	(describe abnormalities)
<input type="checkbox"/>	<input type="checkbox"/>	Appearance/Interaction
<input type="checkbox"/>	<input type="checkbox"/>	Growth
<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"/>	Neck/Nodes
<input type="checkbox"/>	<input type="checkbox"/>	Lungs
<input type="checkbox"/>	<input type="checkbox"/>	Heart/Pulses
<input type="checkbox"/>	<input type="checkbox"/>	Chest/Breasts
<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"/>	Vision (gross assessment/objective)
<input type="checkbox"/>	<input type="checkbox"/>	Hearing (gross assessment/objective)

Signatures: _____

NUTRITIONAL ASSESSMENT:

Typical diet: (specify foods):

Symptoms of eating disorders? Yes / No

Physical Activities:

At least 1hr. exercise daily? Yes / No

Education: Choose variety of foods Sociable at table

Avoid fad diets/eating disorders Select healthy snacks

5 fruits/vegetables daily 2 hrs or less of TV/computer games

DEVELOPMENTAL SURVEILLANCE/ASSESSMENT:

Name of School: Grade: _____ Performance: _____

Peer Relations:

Family Relations:

Extracurricular activities:

Dicussed transition to adult care/self care: _____

Misc.Issues: _____

ANTICIPATORY GUIDANCE:

Social: Family and peer activities Ownership and competition

Responsibility for self and family ETOH use Drug Abuse

Parenting: Establish fair, negotiable rules Money, allowance

Promote mutual & self-respect Respect privacy Allow decisions

Spend time with child talking, projects

Play and communication: Organized sports

Monitor TV and internet use

Health: Dental care Fluoride Personal hygiene Smoking

Second hand smoke Use sunscreen Tick prevention

Sexuality: Prepare for physical changes Masturbation

Modesty Sexual Responsibility STDs

Injury prevention: Seat belt Bicycle helmet Riding in traffic

Smoke detector/escape plan Poison control # Water safety

Protective devices in sports Alcohol/drug use

Firearms (look alike toys; owner risk/safe storage)

PLANS/ORDERS/REFERRALS

- Review immunizations and bring up to date _____
- Labs/testing for any positive risk assessment. -

- Dental visit advised or date of last visit _____
- Next preventive appointment at _____
- Lab tests or other ordered for identified problems _____
- Counseling for identified problems: _____
- Referrals for identified problems: Yes / No (specify) _____

