

PATIENT NAME	DOB	SEX	PARENT NAME
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Allergies	Current Medications
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Prenatal/Family History

Weight	Percentile	Height	Percentile	BMI	Temp.	Pulse	Resp.	BP
	%		%					

History
Interval History:
 (include injury/illness, visits to other health care providers, changes in family or home)

Nutrition

Grains _____ servings per day
 Vegetables _____ servings per day
 Fruits _____ servings per day
 Milk _____ servings per day
 Meat/Beans _____ servings per day

City water Well water Bottled water

Elimination

Normal Abnormal

Sleep

Normal Abnormal

Menstrual

Premenarchal Normal Abnormal

Screening:

Hearing

Screening audiometry, if not done previously
 Parental/child observation/concerns

Vision

Visual acuity
 _____ R _____ L _____ Both
 Objective Screening (required at age 15 & 18)
 Parental/child observation/concerns

Procedures

If High Risk:

IPPD _____ (result)
 Diabetes (type 2) _____ (result)
 Hct or Hgb _____ (result) (Required annually in menstruating females)
 Cholesterol _____ (result)
 STD Screening _____ (result)
 Pelvic Exam _____ (result)
 Urine Test _____ (result)

Immunizations:

Immunizations Reviewed, Given & Charted – *if not given, document rationale*
 MCIR checked/updated

Next Well Check: _____ years of age

Developmental Questions and Observations on Page 2

Provider Signature: _____

Patient Unclothed Y N

Review of Systems		Physical Exam		Systems
N	A	N	A	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	General Appearance
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin/nodes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Head
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eyes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ears
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nose
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Oropharynx
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gums/palate
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck
<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitalia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extremities/hips
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological

Normal Growth and Development
 Tanner Stage _____
 Abnormal Findings and Comments
 If yes, see additional note area on next page
 Results of visit discussed with child/parent
 Y N

Plan

History/Problem List/Meds Updated
 Referrals

Children Special Health Care Needs
 Dental
 Transportation
 Other _____

Other _____

Anticipatory Guidance/Health Education
 (✓ if discussed)

Healthy and Safe Habits

Avoid alcohol, tobacco, drugs, inhalants
 Ensure physical activity & adequate sleep
 Increased responsibility for own health care
 Self Breast/Testicular Exam

Injury and Violence Prevention

Learn to protect self from abuse
 Seat belt use for self and passengers in car
 Responsible Driving/follow speed limits
 Limit time in sun-use sunscreen
 Gun and weapon safety
 Job safety
 Athletic conditioning/Fluids

Mental Health

Feeling sad/angry/fearful
 Handling stress & disappointment
 Handling depression/suicide

Nutrition

Healthy Weight/body image/dieting
 Good eating habits/Food Pyramid
 Teach nutritious and healthy food choices

Oral Health

Schedule dental appointment
 Brush and floss teeth
 No smoking/chewing tobacco

Sexual Development and Education

Discuss development
 Normal sexual feelings
 Preventing pregnancy and STDs
 Gay/Lesbian issues

Social Competence & Responsibility

Peer relationships
 Trust feelings/Listen to friends/adults
 Participation w/social and group activities

Family Support and Relationships

Family support
 Respect others
 Discuss parental limits and consequences

School & Community Interaction

Discuss future plans/College/Career
 Look for and pursue talents & interests
 School frustrations/dropping out
 Encourage to volunteer/participate with religious, school or community activities

WELL CHILD EXAM-ADOLESCENCE: 15-20 Years

DATE	PATIENT NAME	DOB
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Developmental Questions and Observations

You may use the following screening list, or an age appropriate standardized developmental instrument or screening tool.

Ask the patient to respond to the following statements:

Yes No

- Please tell me any questions or concerns you have today:

- I eat breakfast everyday.
- I am happy with how I am doing in school and/or at work.
- I have one or more close friends.
- I feel rested when I wake up.
- I participate in at least one activity and/or interest other than school and work.
- I do things with my family.
- I feel good about my friends and school.
- I know what to do when I feel angry, stressed or frustrated.
- I have someone I can talk to.
- I have questions about sexuality.
- I get some physical activity every day.
- I sometimes feel really down and depressed.
- I sometimes feel very nervous.

If the parent is present, ask the parent to respond to the following statements:

- I am proud of my child.
- I talk to my child about alcohol, drugs, and smoking.
- My child's school work matches his/her future goals.
- My child's school work matches my future goals for him/her.
- I talk to my child about sexuality and our family's values regarding sex.
- I monitor my child's activities and social life.

Please note: Formal developmental examinations are recommended when surveillance suggests a delay or abnormality, especially when the opportunity for continuing observation is not anticipated. (*Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*)

Additional Notes from pages 1 and 2:

Staff Signature: _____ Provider Signature: _____

My Health at 15 - 20 Years

Milestones

Your development between 15 and 20 years of age.

You will keep making more decisions for yourself, plan for your life after high school, and discover new skills and talents.

Being a teenager can be very emotional. This is part of the growing process. You can learn to manage stress and anger. You could take a class with a friend or your parents to learn how to resolve problems.

Teens face many tough choices and may feel more pressures to make the wrong choice. This is an important time to talk to friends, parents, family members and/or trusted teachers to help you learn to make the right choices.

For Help or More Information about:

Firearm safety:

Call 1-202-662-0600 or go to www.safekids.org.

Crisis Intervention/Suicide Prevention Information:

The National Crisis 24/7 Helpline at 1-800-999-9999 or visit www.nineline.org

Girls & Boys Town 24/7 Suicide and Crisis Line: 800-448-3000 or visit www.girlsandboystown.org/hotline

Sexuality Information for teens:

(Planned Parenthood® Federation of America)

www.teenwire.com

Gambling:

24-Hour Gambling Hotline at 1-800-270-7117 or Gamblers Anonymous at www.gamblersanonymous.org

AIDS Hotlines:

24-Hour Hotline (Public Health Service): 1-800-342-2437

Michigan AIDS Hotline (800) 872-2437

Teen Line: (800) 750-TEEN

Eating Disorders:

Call the Eating Disorder Hotline 1-800-931-2237 or visit www.nationaleatingdisorders.org

Domestic Violence hotline:

National Domestic Violence Hotline - (800) 799-SAFE (7233) or the Michigan Coalition Against Domestic & Sexual Violence at 1-517-347-7000.

General information for teens and their parents:

Provides information for teens and parents of teen on many teen topics. <http://www.kidshealth.org/>

Health Tips:

Talk with your doctor at each visit about your health and learn what to do when you have a cold, an earache, or the flu. You should have regular health, hearing and vision check-ups and you should see a dentist at least once a year.

You need at least 8 hours of sleep each night to do your best at school, work or when driving.

A healthy diet is important. You need certain foods to help you grow during your teen years. If you are worried about your weight, check with your doctor. Diet for weight loss should be done only with a doctor or nurse's help. Exercise, healthy foods and fewer snacks are the best way to lose weight.

Learn about your sexuality, abstinence, sexually transmitted diseases and birth control. Be sure you know how and why to say "NO" to sex. Talk to your parents or adult advisor about making sexual decisions.

Everyone feels depressed sometimes. It can be serious so see your doctor or find a counselor if you, or someone you know has several of the following signs for more than two weeks:

- depressed or irritable mood most of the day, nearly every day
- loss of interest or pleasure in usual activities
- noticeable change in appetite or weight (when not dieting or trying to gain weight)
- trouble sleeping or sleeping too much
- speaking and/or moving with unusual speed or slowness
- fatigue or loss of energy nearly every day
- feelings of worthlessness or excessive guilt
- decreased ability to think or concentrate, or unable to make decisions, nearly every day
- thoughts of death, suicide, wishes to be dead or suicide attempts
- Abusing drugs, alcohol or other substances

Safety Tips

Use safety equipment, helmets, pads and seat belts.

Driving is most risky for teenagers when they have other teens in the car. You and your parents should agree on clear rules about driving, especially with your friends.

Never drive drunk or ride with anyone who has been drinking. Remember, "Friends don't let friends drive drunk." They also don't let friends ride with a drunk.

Learn gun safety. Never play around with guns. If there are guns or rifles in your home, make sure they are unloaded and locked up.