PEDIATRIC VISIT 12 TO 13 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:

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

SUBSTANCE USE:

	Tobacco	ETOH	DRUGS
(Circle)	Pos / Neg	Pos / Neg	Pos / Neg

Counseling provided? Yes/No _____
Referral? Yes/No To:_____

MENTAL HEALTH ASSESSMENT:

PHQ-9 completed Yes/No_____
Problem identified? Yes / No _____
Counseling provided? Yes / No _____
Referral? Yes / No To: _____

PHYSICAL EXAMINATION

Wnl	Abn	*(describe abnormalities)*
☐	☐	Appearance/Interaction
☐	☐	Growth
☐	☐	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)*:

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:

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

1. Review immunizations and bring up to date ☐_____
2. Recommend objective Hearing and Vision Tests ☐_____
3. PPD if positive risk assessment ☐_____
4. Testing/counseling if positive cholesterol risk assessment ☐_____
5. Testing if positive STD/HIV risk assessment ☐_____
6. Testing/counseling if positive anemia risk assessment. ☐
7. Dental visit advised ☐ or date of last visit_____
8. Next preventive appointment at _____
9. Referrals for identified problems: Yes / No *(specify)*_____

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Signatures:_____