11-17 Year Well Exam

meridianhealth
A WellCare Company

Date ____________ Patient # ____________
Name ____________ Date of Birth ____________
Address ____________

Lives with: ☐ 1 Parent ☐ 2 Parents ☐ Other Caregiver
☐ Others (including siblings) ____________

May release information to (parent, guardian, other family - list): ____________

Strengths: ____________
Parental concerns: ____________

Changes in child's health since last visit: ____________

ANTICIPATORY GUIDANCE ☐ Check if discussed

FAMILY WELL-BEING:
- ☐ Media limitation, monitor content; NO TV or computer in bedroom
- ☐ Clearly state rules/expectations/responsibilities. Consistently follow through with consequences
- ☐ Family meals, positive attention

BEHAVIOR:
- ☐ Praise positive activities/achievements, not appearance
- ☐ LISTEN, RESPECT adolescent's concerns, opinions, privacy
- ☐ Help with organization/priority setting, dealing with stress
- ☐ Actively discuss delaying sexual behavior, dating, curfew
- ☐ Discuss avoidance of alcohol, tobacco, inhalants, other drugs. Express your values
- ☐ Supervise - anticipate errors in judgment, increased risk-taking

NUTRITION/OBESITY PREVENTION/ORAL HEALTH:
- ☐ Limit junk food - healthy snacks, fruits/vegetables, calcium
- ☐ 1 hour exercise a day
- ☐ Dental hygiene - brushing, flossing BID, exams every 6 months

SAFETY:
- ☐ Know your adolescent's friends and their parents. Discuss what to do if feel unsafe
- ☐ ALWAYS wear seatbelt and use helmet with wheeled activities
- ☐ Sunscreen; no tanning salons
- ☐ Water safety - always swim with someone else, life jacket in boat; protective sports gear
- ☐ Gun safety (including BB guns)
- ☐ Avoid loud noises, especially music from earphones
- ☐ Find ways to deal with stress, conflict - seek professional help if frequently sad, anxious or if thinking of hurting self
- ☐ Substance avoidance; including binge drinking. Designated driver
- ☐ Healthy relationships based on respect, mutual interests. Saying "no" is okay. Sexual safety, safety in relationships

FAMILY HISTORY ☐ Reviewed and updated

SOCIAL HISTORY
Child care: ____________

FAMILY RISK FACTORS
Changes in family since last visit: ____________

STRESS:
How much stress are you and your family under now?
☐ None ☐ Slight ☐ Moderate ☐ **Severe**

What kind of stress?
☐ Relationship ☐ Alcohol ☐ Drugs
☐ Violence/Abuse ☐ Lack of help ☐ Financial
☐ Health Insurance ☐ Child care
☐ Other ____________

How stressful is caring for your child?
☐ None ☐ Slight ☐ Moderate ☐ **Severe**

MATERNAL/CAREGIVER DEPRESSION:
In the past month, have you/partner felt down, depressed or hopeless?
☐ No ☐ Sometimes ☐ **Often**

In the past month, have you/partner felt little interest or pleasure in doing things?
☐ No ☐ Sometimes ☐ **Often**

GENERAL HEALTH

Nutrition/Dental

YES	NO	
☐	☐	Eats 3 meals/day, including breakfast?
☐	☐	4 servings of low-fat dairy?
☐	☐	Juice/pop/soda ______ a day
☐	☐	Fruits and vegetables every day?
☐	☐	Family meals?
☐	☐	Brush/floss teeth?
☐	☐	Has twice yearly dental visit?
☐	☐	Exercises an hour most days?

Sleep: ______ hours through the night

YES	NO	
☐	☐	Problems? ____________

If female: Menarche? ☐ Yes ☐ No When ______
Menses ☐ Regular ☐ Irregular
Bleeding ☐ Normal ☐ Heavy
Cramps ☐ Yes ☐ Normal ☐ Severe
LMP: ____________

DEVELOPMENT

School
Grade: ______ @ ____________ School
Problems? ☐ Yes ☐ No ____________
Activities: ____________
Positive HEADSS questions were discussed ☐ Yes ☐ No
Peer relations: ☐ Good ☐ Concerns ____________
Mood: ☐ Positive ☐ Concerns ____________

11-17 Year Well Exam

meridianhealth
A WellCare Company

MEDICAL HISTORY

Name ______________________ Date of Birth ______________________

Allergies ______________________ Medications ______________________

Major medical illnesses/special healthcare needs ______________________

Hospitalizations/Surgeries ______________________

PHYSICAL EXAMINATION (UNCLOTHED)

Vital Signs: P:______ R:______ T:______ BP:______ /______ Weight ______ (______%) Height ______ (______%)

BMI ______ (______%) Vision Screening R 20/______ L 20/______ Hearing: R______ L ______

Review of Systems

N	Abn	N	Abn		*Comment on abnormal findings*
☐	☐	☐	☐	General appearance	______
☐	☐	☐	☐	Behavior/interaction with family	______
☐	☐	☐	☐	Skin	______
☐	☐	☐	☐	Head/scalp	______
☐	☐	☐	☐	Ears	______
☐	☐	☐	☐	Eyes	______
☐	☐	☐	☐	Nose	______
☐	☐	☐	☐	Mouth/throat	______
☐	☐	☐	☐	Teeth	______
☐	☐	☐	☐	Neck	______
☐	☐	☐	☐	Back/chest	______
☐	☐	☐	☐	Lungs	______
☐	☐	☐	☐	Heart	______
☐	☐	☐	☐	Abdomen	______
☐	☐	☐	☐	Genitalia	______
				Sexual maturity stage	______ breast (female) ______ genitals (male) ______ pubic hair (female & male)
☐	☐	☐	☐	Musculoskeletal	______
☐	☐	☐	☐	Neurological	______

Results reviewed (outside info, lab, etc.) ______________________

Impression ______________________

PLAN OF CARE (see Anticipatory Guidance)

Immunizations ☐ Vaccine Information Statements offered to parent

Past adverse reaction to immunizations: ☐ No ☐ Yes ______________________

☐ Vaccines given ☐ Vaccines refused ______________________

Lab (if indicated) ______________________

Objective Developmental Screening ☐ PEDS/ASQ3/Other (Billing code 96110)

Medical referral (if indicated) ______________________

Handouts ______________________

Return appointment ______________________

Signature ______________________ Date ______________________