16 YEAR CHECKUP CHILD HEALTH RECORD

NAME:
DOB:
GENDER: MALE FEMALE
DATE OF SERVICE:

MEDICAID ID:
PRIMARY CARE GIVER:
PHONE:
INFORMANT:

HISTORY

See new patient history form

INTERVAL HISTORY:

NKDA Allergies:

Sexually Active: Y N

Last Menstrual Period: ____________

Menstrual Cycle # Days: ____________

Current Medications:

If sexually active using contraception: Y N

Visits to other health-care providers, facilities:

Parental concerns/changes/stressors in family or home:

Psychosocial/Behavioral Health Issues: Y N

Findings:

DEVELOPMENTAL/MENTAL HEALTH SCREENING:
(use of validated tool required)

PSC-17 PSC-35 Y-PSC PHQ-9 CRAFFT

PHQ-A (AAP tool: anxiety, eating disorders, etc.)

PHQ-A (depression screening) RAAPS P F

Findings:

TUBERCULOSIS:

TB questionnaire*, risk identified: Y N

**Tuberculin Skin Test if indicated* TST

(TB questionnaire-Page 2)

NUTRITION*: Problems: Y N Assessment:

**See Bright Futures Nutrition Book if needed*

IMMUNIZATIONS

Up to date Deferred

Reason (if deferred):

Given today: Hep A* Hep B HPV Td/Tdap

Meningococcal MMR Pneumococcal*

Varicella Influenza

**Special populations: See ACIP*

LABORATORY

Tests ordered today:

HIV (required once 16-18 year)

Other:

Signature/title

UNCLOTHED PHYSICAL EXAM

See growth graph

Weight: _______ (______%) Height: _______ (______%)

BMI: _______ (______%) Heart Rate: ____________

Blood Pressure: _____/_____ Respiratory Rate: __________

Temperature (optional): _________

Normal (Mark here if all items are WNL)

Abnormal (Mark all that apply and describe):

Appearance	Nose	Lungs
Head	Mouth/throat	GI/abdomen
Skin	Teeth	Extremities
Eyes	Neck	Back
Ears	Heart	Musculoskeletal
		Neurological

Abnormal findings:

Additional:

Tanner Stage

Breasts _____/5 Genitalia _____/5

SENSORY SCREENING:

Subjective Hearing Screening: P F

Subjective Vision Screening: P F

HEALTH EDUCATION/ANTICIPATORY GUIDANCE *(See back for useful topics)*

Selected health topics addressed in any of the following areas*:

- Physical Growth and Development
- Social and Academic Competence
- Nutrition
- Safety

**See Bright Futures for assistance*

ASSESSMENT

PLAN/REFERRALS

Dental Referral: Y

Other Referral(s)

Return to office:

Signature/title

Name:	Medicaid ID:

Typical Developmentally Appropriate Health Education Topics

16 Year Old Checkup

- Provide nutritious meals and snacks; limit sweets/sodas/high-fat foods
- Discuss family expectations concerning dating/sexual contact/abstinence/substance use/peer pressure
- Encourage physical activity for 1 hour/day
- Establish consistent limits/rules and consistent consequences
- Increase difficulty of chores to develop sense of family responsibility/self accomplishment
- Limit TV/computer time to 2 hours/day
- Pregnancy/STI prevention
- Promote healthy weight
- Self-breast/testicular exam
- Discuss self-safety in stalking/abusive relationship/bullying
- Do not ride in a car if use of alcohol/drugs involved
- During sports wear protective gear at all times
- Get to know teen's friends and their parents
- Lock up guns, enroll in gun safety class if interested
- Promote use of seat belt
- Provide information about sexuality/risks involved in sexual activity
- Teach self-safety at friend's home/car and how to exit situation
- Discuss additional help with teacher if there are concerns/bullying
- Discuss nonviolent conflict resolution, demonstrate anger management at home
- Discuss school activities and school work
- Encourage independent decision-making skills/thinking through steps of a project/encourage involvement in family decisions
- Establish an agreed-on curfew, after-school activities
- Establish self-responsibility for homework completion
- Observe for signs of depression/anxiety or other mental health issues
- Provide space/time for homework/personal time
- Discuss tobacco use

TB QUESTIONNAIRE

Place a mark in the appropriate box:	Yes	Do not know	No
Have you been tested for TB? If yes, when (date)			
Have you ever had a positive Tuberculin Skin Test? If yes, when (date)			
TB can cause fever that lasts for days or weeks, unexplained weight loss, a bad cough (lasting over two weeks), or coughing up blood. As far as you know:			
have you been around anyone with any of these symptoms or problems?			
have you been around anyone sick with TB?			
have you had any of these symptoms or problems?			
Were you born in Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe, or Asia?			
Have you traveled in the past year to Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe, or Asia for longer than 3 weeks? If so, specify which country/countries?			
To your knowledge, have you spent time (longer than 3 weeks) with anyone who is/has been an intravenous (IV) drug user, HIV-infected, in jail or prison, or has recently come to the United States from another country?			