

NAME:
DOB:
GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
DATE OF SERVICE:

MEDICAID ID:
PRIMARY CARE GIVER:
PHONE:
INFORMANT:

HISTORY

See new patient history form

INTERVAL HISTORY:

NKDA Allergies:

Current Medications:

Visits to other health-care providers, facilities:

Parental concerns/changes/stressors in family or home:

Psychosocial/Behavioral Health Issues: Y N
Findings:

TB questionnaire*, risk identified: Y N
*Tuberculin Skin Test if indicated TST
(See back for form)

NUTRITION*:

Problems: Y N
Assessment:

*See Bright Futures Nutrition Book if needed

IMMUNIZATIONS

Up-to-date
 Deferred - Reason:

Given today: Hep A Hep B HPV IPV
 Td/Tdap Meningococcal* MMR MMRV
 Pneumococcal* Varicella Influenza

*Special populations: See ACIP

LABORATORY

Tests ordered today:
Dyslipidemia Screening (required once 9 -11 years)
Other:

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):

- | | | |
|-------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Appearance | <input type="checkbox"/> Nose | <input type="checkbox"/> Lungs |
| <input type="checkbox"/> Head | <input type="checkbox"/> Mouth/throat | <input type="checkbox"/> GI/abdomen |
| <input type="checkbox"/> Skin | <input type="checkbox"/> Teeth | <input type="checkbox"/> Extremities |
| <input type="checkbox"/> Eyes | <input type="checkbox"/> Neck | <input type="checkbox"/> Back |
| <input type="checkbox"/> Ears | <input type="checkbox"/> Heart | <input type="checkbox"/> Musculoskeletal |
| | | <input type="checkbox"/> Neurological |

Abnormal findings:

Additional:

Tanner Stage
Breasts _____/5 Genitalia _____/5

Audiometric Screening:

R 1000Hz _____ 2000HZ _____ 4000HZ _____
L 1000Hz _____ 2000HZ _____ 4000HZ _____

Visual Acuity Screening:

OD _____/____ OS _____/____ OU _____/____

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

Selected health topics addressed in any of the following areas*

- | | |
|---------------------------------|---------------|
| • School Performance | • Nutrition |
| • Physical Activity | • Oral Health |
| • Development and Mental Health | • Safety |

*See Bright Futures for assistance

ASSESSMENT

PLAN/REFERRALS

Dental Referral: Y
Other Referral(s)

Return to office:

Signature/title

Signature/title

Name:

Medicaid ID:

Typical Developmentally Appropriate Health Education Topics

10 Year Old Checkup

- Discuss puberty and physical changes/sexuality
- Encourage constructive conflict resolution, demonstrate anger management at home
- Establish consistent limits/rules and consistent consequences
- Establish personal hygiene routine
- Increase difficulty of chores to develop sense of accomplishment and increase self-confidence
- Limit TV/computer time to 2 hours/day
- Provide nutritious meals and snacks; limit sweets/sodas/high-fat foods
- Establish tooth brushing routine twice a day
- During sports wear protective gear at all times
- Encourage outdoor play for 1 hour/day
- Develop a family plan for exiting house in a fire/establish meeting place after exit
- Discuss drug/tobacco/alcohol use and peer pressure
- Get to know child's friends and their parents
- Lock up guns
- Promote use of seat belt and ride in back seat until 12 years old
- Provide home safety for fire/carbon monoxide poisoning
- Provide safe/quality after-school care
- Supervise when near or in water even if child knows how to swim
- Teach self-safety if feeling unsafe at friend's home/car, answer the door/telephone when adult not home, personal body privacy
- Discuss additional help with teacher if there are concerns/bullying
- Discuss school activities and school work
- Provide space/time for homework/personal time

TB QUESTIONNAIRE	Place a mark in the appropriate box:		
	Yes	Do not know	No
Has your child been tested for TB? If yes, when (date)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has your child ever had a positive Tuberculin Skin Test? If yes, when (date)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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:			
has your child been around anyone with any of these symptoms or problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
has your child been around anyone sick with TB?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
has your child had any of these symptoms or problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was your child born in Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe, or Asia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has your child 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
To your knowledge, has your child 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>