NAME:	MEDICAID ID:
DOB:	PRIMARY CARE GIVER:
GENDER: MALE FEMALE	PHONE:
DATE OF SERVICE:	INFORMANT:

HISTORY

See new patient history form

INTERVAL HISTORY:

NKDA Allergies:

Last Menstrual Period: _______________
Menstrual Cycle # Days: _____________

Current Medications:

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 TST
Tuberculin Skin Test if indicated (TB questionnaire: p. 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 IPV
Td/Tdap Meningococcal MMR MMRV
Pneumococcal* Varicella Influenza

**Special populations: See ACIP*

LABORATORY

Tests ordered today:

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:

Visual Acuity Screening:
OD____/_____ OS____/_____ OU____/_____

Subjective Hearing 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
- Nutrition
- Social and Academic Competence
- Safety
- Family Adjustment

**See Bright Futures for assistance*

ASSESSMENT

PLAN/REFERRALS

Dental Referral: Y
Other Referral(s)

Return to office:

Signature/title

12 YEAR CHECKUP CHILD HEALTH RECORD

Name: | Medicaid ID:

Typical Developmentally Appropriate Health Education Topics

12 Year Old Checkup

- Provide nutritious meals and snacks; limit sweets/sodas/high-fat foods
- Discuss puberty and physical changes/sexuality
- Encourage constructive conflict resolution, demonstrate anger management at home
- Encourage personal hygiene routine
- 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
- Develop a family plan for exiting house in a fire/establish meeting place after exit
- Discuss drug/tobacco/alcohol use and peer pressure
- Do not allow riding in a car with teens who use alcohol/drugs
- Get to know child's friends and their parents
- Lock up guns, enroll in gun safety class if interested
- 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/appropriate 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
- During sports wear protective gear at all times
- 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)			
Has your child 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:			
has your child been around anyone with any of these symptoms or problems?			
has your child been around anyone sick with TB?			
has your child had any of these symptoms or problems?			
Was your child born in Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe, or Asia?			
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?			
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?			