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

17 YEAR CHECKUP CHILD HEALTH RECORD

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
- Nutrition
- Social and Academic Competence
- 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

17 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?	☐	☐	☐