

# Well Child Exam

Adolescence 15 to 20 Years



15-20 years

Date								
Patient Name				DOB	Sex	Parent Name		
Allergies				Current Medications				
Prenatal / Family History					Ethnicity			
Weight	Percentile	Height	Percentile	BMI	Temp.	Pulse	Resp.	BP
	%		%					

<b>Interval History</b> (include injury/illness, visits to other health care providers, changes in family or home) _____ _____
<b>Nutrition</b> <input type="checkbox"/> Grains _____ servings per day <input type="checkbox"/> Vegetables _____ servings per day <input type="checkbox"/> Fruits _____ servings per day <input type="checkbox"/> Milk _____ servings per day <input type="checkbox"/> Meat/Beans _____ servings per day <input type="checkbox"/> City water <input type="checkbox"/> Well water <input type="checkbox"/> Bottled water <input type="checkbox"/> Fluoride prescribed
<b>Elimination</b> <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
<b>Sleep</b> <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
<b>Menstrual</b> <input type="checkbox"/> Premenarchal <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
<b>Screening</b> <b>Hearing</b> <input type="checkbox"/> Screening audiometry, if not done previously <input type="checkbox"/> Parental observation/concerns <b>Vision</b> <input type="checkbox"/> Visual acuity _____ R _____ L _____ Both <input type="checkbox"/> Parental/child observation/concerns <b>Procedures</b> If High Risk: <input type="checkbox"/> IPPD _____ (result) <input type="checkbox"/> Diabetes (type 2) _____ (result) <input type="checkbox"/> Hct or Hgb _____ (result) (Required annually in menstruating females) <input type="checkbox"/> Cholesterol _____ (result) <input type="checkbox"/> STD Screening _____ (result) <input type="checkbox"/> Pelvic Exam _____ (result) <input type="checkbox"/> Urine Test _____ (result)
<b>Immunizations</b> <input type="checkbox"/> Immunizations Reviewed, Given, & Charted – if not given, document rationale <input type="checkbox"/> MCIR checked/updated <input type="checkbox"/> VIS given <input type="checkbox"/> Flu if high risk <input type="checkbox"/> Pneumonia if high risk
<b>Developmental Questions and Observations on Page 2</b>
<b>Next Well Check:</b> _____ years of age
Provider Signature: _____

Patient unclothed <input type="checkbox"/> Y <input type="checkbox"/> N				
Review of Symptoms		Physical Exam		Systems
N	A	N	A	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	General appearance
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin/nodes/rash
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Head/fontanel
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eyes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ears
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nose
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Oropharynx
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gums/palate
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lungs
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart/pulses
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitalia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extremities/hips
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological
<input type="checkbox"/> Normal Growth and Development <input type="checkbox"/> Tanner Stage _____ <input type="checkbox"/> Abnormal Findings and Comments If yes, see additional note area on next page Results of visit discussed with child/parent <input type="checkbox"/> Y <input type="checkbox"/> N				
Plan <input type="checkbox"/> History/Problem List/Meds Updated <input type="checkbox"/> Referrals <input type="checkbox"/> Children Special Health Care Needs <input type="checkbox"/> Dental <input type="checkbox"/> Transportation				
<input type="checkbox"/> Priority Health case mgmt 800 998-1037 <input type="checkbox"/> Other _____				

<b>Anticipatory Guidance / Health Education</b> (✓ if discussed)
<b>Healthy and Safe Habits</b> <input type="checkbox"/> Avoid alcohol, tobacco, drugs, inhalants <input type="checkbox"/> Ensure physical activity & adequate sleep <input type="checkbox"/> More responsibility for own health care <input type="checkbox"/> Self breast/testicular exam
<b>Injury and Illness Prevention</b> <input type="checkbox"/> Learn to protect self from abuse <input type="checkbox"/> Seat belt use for self/ passengers in car <input type="checkbox"/> Responsible driving/follow speed limits <input type="checkbox"/> Limit time in sun-use sunscreen <input type="checkbox"/> Gun and weapon safety <input type="checkbox"/> Athletic conditioning/fluids <input type="checkbox"/> Use bike helmet/protective sporting gear
<b>Mental Health</b> <input type="checkbox"/> Feeling sad/angry/fearful <input type="checkbox"/> Handling stress & disappointment <input type="checkbox"/> Handling depression/suicide
<b>Nutrition</b> <input type="checkbox"/> Healthy weight/body image/dieting (anorexia, bulimia) <input type="checkbox"/> Good eating habits/food pyramid <input type="checkbox"/> Teach nutritious and healthy food choices
<b>Oral Health</b> <input type="checkbox"/> Schedule dental appointment <input type="checkbox"/> Brush and floss teeth <input type="checkbox"/> No smoking/chewing tobacco
<b>Sexual Development and Education</b> <input type="checkbox"/> Discuss development <input type="checkbox"/> Normal sexual feelings <input type="checkbox"/> Preventing pregnancy <input type="checkbox"/> STIs (Chlamydia, Gonorrhea) <input type="checkbox"/> Gay/Lesbian issues
<b>Social Competence and Responsibility</b> <input type="checkbox"/> Peer relationships <input type="checkbox"/> Trust feelings/listen to friends/adults <input type="checkbox"/> Participation w/social and group activities
<b>Family Support and Relationships</b> <input type="checkbox"/> Family support <input type="checkbox"/> Respect others <input type="checkbox"/> Discuss parental limits and consequences
<b>School &amp; Community Interaction</b> <input type="checkbox"/> Discuss future plans/college/career <input type="checkbox"/> Look for and pursue talents & interests <input type="checkbox"/> School frustrations/dropping out <input type="checkbox"/> Encourage to volunteer/participate with religious, school, or community activities

Date	Patient Name	DOB
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### Developmental Questions and Observations

You may use the following screening list, or an age-appropriate standardized developmental instrument or screening tool.\*

Ask the patient to respond to the following statements:

Yes      No

- Please tell me any questions or concerns you have today:  
\_\_\_\_\_
- I eat breakfast every day.
- I am happy with how I am doing in school and/or at work.
- I have one or more close friends.
- I feel rested when I wake up.
- I participate in at least one activity and/or interest other than school and work.
- I do things with my family.
- I feel good about my friends and school.
- I know what to do when I feel angry, stressed, or frustrated.
- I have someone I can talk to.
- I have questions about sexuality.
- I get some physical activity every day.
- I sometimes feel really down and depressed.
- I sometimes feel very nervous.

If the parent is present, ask the parent to respond to the following statements:

- I am proud of my child.
- I talk to my child about alcohol, drugs, and smoking.
- My child's school work matches his/her future goals.
- My child's school work matches my future goals for him/her.
- I talk to my child about sexuality and our family's values regarding sex.
- I monitor my child's activities and social life.

\*Please note: Formal developmental examinations are recommended when surveillance suggests a delay or abnormality, especially when the opportunity for continuing observation is not anticipated. (*Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*)

Additional notes from pages 1 and 2:

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### Family History Update

Since your last visit, have there been any changes in your family history? Include:

- Deaths: who \_\_\_\_\_ what age \_\_\_\_\_
- New medical diagnosis: who \_\_\_\_\_ what age \_\_\_\_\_
- Anything else in your family history you have concerns or questions with: (Refer to Family History form)

Staff Signature: \_\_\_\_\_ Provider Signature: \_\_\_\_\_

This HME form was developed by the Institute for Health Care Studies at Michigan State University in collaboration with the Michigan Medicaid managed care plans, Michigan Department of Community Health, Michigan Association of Health Plans, and Michigan Association of Local Public Health. Adapted with permission by Priority Health 9/06.

## Patient Education:

Adolescence: 15 - 20 Years

### Milestones: Your development between 15 and 20 years of age

- You will keep making more decisions for yourself, plan for your life after high school, and discover new skills and talents.
- Being a teenager can be very emotional. This is part of the growing process. You can learn to manage stress and anger. You could take a class with a friend or your parents to learn how to resolve problems.
- Teens face many tough choices and may feel more pressures to make the wrong choice. This is an important time to talk to friends, parents, family members, and/or trusted teachers to help you learn to make the right choices.

### Safety Tips

- Use safety equipment, helmets, pads, and seat belts.
- Driving is most risky for teenagers when they have other teens in the car. Agree with your parents on clear rules about driving.
- Never drive drunk or ride with anyone who has been drinking. Remember, "Friends don't let friends drive drunk." They also don't let friends ride with a drunk.
- Learn gun safety. Never play around with guns. If there are guns or rifles in your home, make sure they are unloaded and locked up.

### Health Tips

- Talk with your doctor at each visit about your health and learn what to do when you have a cold, an earache, or the flu. Ask if you need a flu or pneumonia shot. You should have regular health, hearing, and vision check-ups. See a dentist at least once a year.
- Practice "saying no" to tobacco, drugs and alcohol. If you smoke, let your doctor know. Your doctor can refer you for tobacco cessation classes, nicotine replacement therapies, or to the Priority Health Healthy Encounters-Tobacco Cessation Quit Line at 800 446-5674.
- You need at least 8 hours of sleep each night to do your best at school, at work, or when driving.
- A healthy diet is important. If you are worried about your weight, check with your doctor. Diet for weight loss should be done only with a doctor or nurse's help. Exercise, healthy foods, and fewer snacks are the best way to lose weight.
- Learn about sexuality, abstinence, safe sex, sexually transmitted infections (Chlamydia and gonorrhea), and birth control. Be sure you know how and why to say "NO" to sex. Talk to your parents or an adult about making sexual decisions.
- Everyone feels depressed sometimes. It can be serious, so see your doctor or find a counselor if you or someone you know has several of the following signs for more than two weeks:
  - o depressed or irritable mood most of the day, nearly every day
  - o loss of interest or pleasure in usual activities
  - o noticeable change in appetite or weight (when not dieting or trying to gain weight); eating disorders (anorexia, bulimia)
  - o trouble sleeping or sleeping too much
  - o speaking and/or moving with unusual speed or slowness
  - o fatigue or loss of energy nearly every day
  - o feelings of worthlessness or excessive guilt
  - o decreased ability to think or concentrate, or unable to make decisions, nearly every day
  - o thoughts of death, suicide, or suicide attempts
  - o abusing drugs, alcohol, or other substances

## For Help or More Information

### Priority Health

Customer Service 616 942-1221 or 800 446-5674  
 Medicaid 888 975-8102  
 Behavioral Health 616 464-8500 or 800 673-8043  
[priorityhealth.com](http://priorityhealth.com)

### Mental Health

Association for Children's Mental Health (ACMH)  
 888 226-4543

### Crisis Intervention/Suicide Prevention Information

The National Crisis 24/7 Helpline at 800 999-9999 or  
[www.nineline.org](http://www.nineline.org)

### Girls & Boys Town 24/7 Suicide and Crisis Line

800 448-3000 or [www.girlsandboystown.org/hotline](http://www.girlsandboystown.org/hotline)

### Gambling

24-Hour Gambling Hotline 800 270-7117  
 Gamblers Anonymous [www.gamblersanonymous.org](http://www.gamblersanonymous.org)

### Eating Disorders

Eating Disorder Hotline 800 931-2237  
[www.nationaleatingdisorders.org](http://www.nationaleatingdisorders.org)

### AIDS Hotlines

24-Hour Hotline (Public Health Service) 800 342-2437  
 Michigan AIDS Hotline 800 872-2437  
 Teen Line 800 750-8336

### Domestic Violence

National Domestic Violence Hotline  
 800 799-SAFE (7233)

### Child Abuse and Neglect Information Hotline

800 942-4357  
 Michigan Coalition Against Domestic &  
 Sexual Violence  
 517 347-7000

### Parenting Skills or Support

Parents Hotline 800 942-4357  
 Family Support Network of Michigan  
 800 359-3722

### Prevention of Unintentional Childhood Injuries

National Safe Kids Campaign  
 Safe Gun Storage Information  
 202 662-0600  
[www.safekids.org](http://www.safekids.org)

### Fire Safety

Talk with firefighters at your local fire station

### Poison Prevention

Call the Poison Control Center  
 800 222-1222

### Resources for Teens and Their Parents:

[www.kidshealth.org](http://www.kidshealth.org)  
[www.teenwire.com](http://www.teenwire.com) (sexuality information for teens)