

Well Child Exam



Adolescence: 15-20 years

Date									
Patient name				DOB	Sex	Parent name			
Allergies					Current medications				
Prenatal/family history						Ethnicity			
Weight	Percentile	Height	Percentile	BMI	Percentile	Temp.	Pulse	Resp.	BP
	%		%		%				

Interval history
(include injury/illness, visits to other health care providers, changes in family or home)

Nutrition

Grains _____ servings per day
 Vegetables _____ servings per day
 Fruits _____ servings per day
 Milk _____ servings per day
 Meat/beans _____ servings per day
 City water Well water
 Bottled water Fluoride prescribed

Elimination

Normal Abnormal

Sleep

Normal Abnormal

Menstrual

Premenarchal Normal Abnormal

Screening

Hearing

Screening audiometry, if not done previously
 Parental observation/concerns

Vision

Visual acuity ___R ___L ___Both
 Parental/child observation/concerns

Procedures

If high risk:

IPPD _____ (result)
 Diabetes (type 2) _____ (result)
 Hct or Hgb _____ (result - required annually in menstruating females)
 Cholesterol _____ (result)
 STD screening _____ (result)
 Pelvic exam _____ (result)
 Urine test _____ (result)

Immunizations

Immunizations reviewed, given & charted – if not given, document rationale
 MCIR checked/updated VIS given
 Flu if high risk Pneumonia if high risk

Developmental questions and observations on page 2

Next Well Check: ___ years of age

Provider signature:

Patient unclothed Y 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

Normal growth and development
 Tanner Stage _____
 Abnormal findings and comments
 If yes, see additional note area on next page

Results of visit discussed with child/parent
 Y N

Plan

History/problem list/meds updated
 Referrals
 Dental Transportation
 Children Special Health Care Needs
 Priority Health Case Mgmt 800 998-1037
 Other _____

Anticipatory guidance/health education
(✓ if discussed)

Healthy and safe habits

Avoid alcohol, tobacco, drugs, inhalents
 Ensure physical activity and adequate sleep
 More responsibility for own health care
 Self breast/testicular exam

Injury and illness prevention

Learn to protect self from abuse
 Seat belt use for self/passengers in car
 Responsible driving/follow speed limits
 Limit time in sun - use sunscreen
 Gun and weapon safety
 Athlete conditioning/fluids
 Use bike helmet/protective sporting gear

Mental health

Feeling sad/angry/fearful
 Handling stress and disappointment
 Handling depression/suicide

Nutrition

Healthy weight/body image/dieting (anorexia, bulimia)
 Good eating habits/food pyramid
 Teach nutritious and healthy food choices

Oral health

Schedule dental appointment
 Brush and floss teeth
 No smoking/chewing tobacco

Sexual development and education

Discuss development
 Normal sexual feelings
 Preventing pregnancy
 STIs (Chlamydia, Gonorrhea)
 Gay/Lesbian issues

Social competence and responsibility

Peer relationships
 Trust feelings/listen to friends/adults
 Participation with social and group activities

Family support and relationships

Family support
 Respect others
 Discuss parental limits and consequences

School and community interaction

Discuss future plans/college/career
 Look for and pursue talents and interests
 School frustrations/dropping out
 Encourage to volunteer/participate with religious, school or community activities

Physical activity

Assess and counsel on ways to increase activity level

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.
- I don't use tobacco.

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

- Yes No
- I am proud of my child.
- I talk to my child about alcohol, drugs, smoking and sex.
- 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:

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. Implemented 1997; Last redesign; December 2006.

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. After high school is a good time to begin thinking about a Reproductive Life Plan (family planning) too. Ask your doctor for more information.
- 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

- Healthy eating is important. Talk with your doctor about ways to improve healthy eating.
- Keep active. Talk with your doctor about ways to increase your activity levels.
- 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. Ask your doctor about preconception counseling.

- 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:
 - Depressed or irritable mood most of the day, nearly every day
 - Loss of interest or pleasure in usual activities
 - Noticeable change in appetite or weight (when not dieting or trying to gain weight); eating disorders (anorexia, bulimia)
 - Trouble sleeping or sleeping too much
 - Speaking and/or moving with unusual speed or slowness
 - Fatigue or loss of energy nearly every day
 - Feelings of worthlessness or excessive guilt
 - Decreased ability to think or concentrate, or unable to make decisions, nearly every day
 - Thoughts of death, suicide, or suicide attempts
 - 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

Mental health

Association for Children's Mental Health (ACMH)
 800 226-4543

Crisis Intervention/Suicide Prevention Information

The National Crisis 24/7 Helpline
 800 999-9999, npline.org

Girls & Boys Town 24/7 Suicide and Crisis Line

800 448-3000, girlsandboystown.org/hotline

Gambling

24-Hour Gambling Hotline, 800 270-7117
 Gamblers Anonymous, gamblersanonymous.org

Eating Disorders

Eating Disorder Hotline 800 931-2237
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, 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

kidshealth.org
teenwire.com (sexuality information for teens)