

# 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  
 Whole Milk \_\_\_\_\_ servings per day  
 Meat/Beans \_\_\_\_\_ servings per day  
 City water  Well water  
 Bottled water  Fluoride prescribed

**Elimination**

Normal  Abnormal

**Exercise Assessment**

Physical activity \_\_\_\_\_ minutes per day

**Sleep**

Normal  Abnormal  
 Abnormal Findings and Comments  
 Additional area for comments on page 2

**Menstrual**

Premenarchal  Normal  Abnormal

**Screening**

**Hearing**  
 Screening audiometry, if not done previously  
 Parental observation/concerns

**Vision**  
 Visual acuity (at 15 & 18 years)  
 \_\_\_\_\_ R \_\_\_\_\_ L \_\_\_\_\_ Both  
 Parental/child observation/concerns

**Developmental Surveillance**  
 Social-Emotional  Communicative  
 Cognitive  Physical Development

**Psychosocial/Behavioral assessment**  Y  N

**Alcohol & Drug use (risk assessment)**  Y  N

**Screening for abuse**  Y  N

**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)  
 Dyslipidemia \_\_\_\_\_ (result) to be done once between 18 and 20 years old  
 Cervical dysplasia \_\_\_\_\_ (result)

**Immunizations**

Immunizations reviewed, given & charted – if not given, document rationale  
 Tdap  HPV  MCV4  
 MCIR checked/updated  VIS given  
 Flu if high risk  Pneumonia if high risk

**Developmental questions and observations on page 2**

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 \_\_\_\_\_

**Next Well Check: \_\_\_\_\_ years of age**

Provider signature:  
 X \_\_\_\_\_

**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  
 Make a plan if in unsafe situation  
 Seat belt use for self/passengers in car  
 Responsible driving/follow speed limits  
 Swimming/water safety  
 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  
 Eat meals as a family

**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  
 Avoid risky or violent situations  
 Healthy dating relationships

**Social competence and responsibility**

Peer relationships  
 Trust feelings/listen to friends/adults  
 Participation with social and group activities  
 Feeling sad/angry/fearful  
 Handling depression/suicide

**Family support and relationships**

Family support  
 Respect others  
 Discuss parental limits and consequences  
 Substance abuse, child abuse, domestic violence prevention, depression  
 Know who your teen spends time with  
 Spend family time together  
 Home, school, community rules

**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  
 Limit TV, video, and computer games

Date	Patient Name	DOB
------	--------------	-----

### 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                       |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Please tell me any questions or concerns you have today:                           |
| <hr/>                    |                          |  |
| <input type="checkbox"/> | <input type="checkbox"/> | I eat breakfast every day.   |
| <input type="checkbox"/> | <input type="checkbox"/> | I am happy with how I am doing in school and/or at work.                           |
| <input type="checkbox"/> | <input type="checkbox"/> | I have one or more close friends.  |
| <input type="checkbox"/> | <input type="checkbox"/> | I feel rested when I wake up.  |
| <input type="checkbox"/> | <input type="checkbox"/> | I participate in at least one activity and/or interest other than school and work. |
| <input type="checkbox"/> | <input type="checkbox"/> | I do things with my family.  |
| <input type="checkbox"/> | <input type="checkbox"/> | I feel good about my friends and school.   |
| <input type="checkbox"/> | <input type="checkbox"/> | I know what to do when I feel angry, stressed, or frustrated.                      |
| <input type="checkbox"/> | <input type="checkbox"/> | I have someone I can talk to.  |
| <input type="checkbox"/> | <input type="checkbox"/> | I have questions about sexuality.  |
| <input type="checkbox"/> | <input type="checkbox"/> | I get some physical activity every day.  |
| <input type="checkbox"/> | <input type="checkbox"/> | I sometimes feel really down and depressed.  |
| <input type="checkbox"/> | <input type="checkbox"/> | I sometimes feel very nervous.   |
| <input type="checkbox"/> | <input type="checkbox"/> | I don't use tobacco.   |

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

- | Yes                      | No                       |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | I am proud of my child.   |
| <input type="checkbox"/> | <input type="checkbox"/> | I talk to my child about alcohol, drugs, smoking and sex.                 |
| <input type="checkbox"/> | <input type="checkbox"/> | My child's school work matches his/her future goals.                      |
| <input type="checkbox"/> | <input type="checkbox"/> | My child's school work matches my future goals for him/her.               |
| <input type="checkbox"/> | <input type="checkbox"/> | I talk to my child about sexuality and our family's values regarding sex. |
| <input type="checkbox"/> | <input type="checkbox"/> | 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 9/10. Implemented 1997; Last redesign; September 2010.

# 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. You need certain foods to help you grow during the teen years. 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. Make a goal to be physically active at least 60 minutes each day. It doesn’t have to be all at once. Find activities that you enjoy.
- 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

*continued >*

## 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, 800 999-9999, [nineline.org](http://nineline.org)

### Girls & Boys Town 24/7 suicide and crisisline

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

### Gambling

Gambling Hotline 800 270-7117  
 Gamblers Anonymous 888 844-2891, [gamblersanonymous.org](http://gamblersanonymous.org)

### Eating disorders

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

### AIDS hotlines

24-Hour Hotline (Public Health Service), 800 342-2437  
 Michigan AIDS Hotline, 800 872-2437  
 Teen line, 800 750-8336  
 National AIDS Hotline, 800 CDC-INFO (232-4636) or online at [cdc.gov](http://cdc.gov)  
 AIDS.GOV website online at [aids.gov](http://aids.gov)

### Domestic violence

National Domestic Violence Hotline, 800 799-SAFE (7233), [ndvh.org](http://ndvh.org)

### 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 and Safe Gun Storage Information  
 202 662-0600, [safekids.org](http://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](http://kidshealth.org)  
 Sexuality information for teens (Planned Parenthood® Federation of America)  
[teenwire.com](http://teenwire.com)