### History

- **BF** Previsit Questionnaire reviewed
- Teen has a dental home
- Teen has special health care needs

- BF Concerns/questions raised by
  - None
  - Addressed (see other side)

- BF Follow-up on previous concerns
  - None
  - Addressed (see other side)

  **Menarche age**: ___________
  **Regularity**: ___________

- BF Menstrual problems
  - Medication Record reviewed and updated

### Social/Family History

- Single Parent
- Changes since last visit
- Teen lives with
- Relationship with parents/siblings
  - Tobacco Exposure

### Risk Assessment

If not reviewed in Supplemental Questionnaire (Use other side if risks identified.)

- Date of last visit ___________

**BF**

### Physical Examination

- **= Reviewed w/Findings**
- **OR**
- ___________ = NL

**BF**

- GENERAL APPEARANCE
  - SKIN
  - HEAD
  - EYES
  - EARS
  - NOSE
  - THROAT
  - MOUTH/TEETH
  - NECK
  - LUNGS
  - HEART
  - GI / ABDOMEN

- BREASTS (discuss self-exam)
- GENITAIL
- SEXUAL MATURITY RATING
- TESTICLE (discuss self-exam)
- NEUROLOGIC/GAIT
- EXTREMITIES
- MUSCULOSKELETAL
- HYGIENE

### Assessment

- BF Well Teen

### Anticipatory Guidance

- = Discussed and/or handout given

  - Identified at least one child and parent strength
  - Counseled on smoking cessation if tobacco user
  - Discuss 5-2-1-0, fast food, avoid juice/soda/candy
  - Help with homework when needed

**BF**

- PHYSICAL GROWTH AND DEVELOPMENT
  - Balanced diet
  - Physical activity
  - Limit TV
  - Protect hearing
  - Brush/Floss teeth
  - Regular dentist visits

- SOCIAL AND ACADEMIC COMPETENCE
  - Age-appropriate limits
  - Friends/relationships
  - Family time
  - Community involvement
  - Encourage reading/school
  - Rules/Expectations
  - Planning for after high school
  - Education: expectations, preparation, and options

**BF**

- RISK REDUCTION
  - Tobacco, alcohol, drugs
  - Prescription drugs
  - Sex
  - VIOLENCE AND INJURY PREVENTION
  - Seat belts
  - Guns
  - Conflict resolution
  - Driving restriction
  - Sports/Recreation safety
# WELL CHILD VISIT

## 15 to 21 Years

<table>
<thead>
<tr>
<th>NAME</th>
<th>Male</th>
<th>Female</th>
<th>Medical Record Number</th>
<th>DOB</th>
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<table>
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<tr>
<th>Actual age:</th>
<th>Months:</th>
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<tbody>
<tr>
<td>______</td>
<td>______</td>
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</table>

## Current Medications

________________________________________

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## Plan

**BF** Patient is up to date, based on CDC/ACIP immunization schedule.

- [ ] Yes
- [ ] No

If no, immunizations given today.

ImmmPact2 record reflects current immunization status:

- [ ] Yes
- [ ] No

Immunization plan/comments ______________________________________________________

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**Oral Health**

- Oral health risk assessment [ ] Completed [ ] Low  [ ] Mod  [ ] High
- Has a dental home [ ] Yes  [ ] No
- Dental fluoride varnish applied [ ] Yes  [ ] No
- Dental Visit in Past Year [ ] Yes  [ ] No
- Well water testing [ ] Yes  [ ] No

**MaineCare Member Support Requested**

- Transportation to appointments [ ]
- Find dentist [ ]
- Find other provider [ ]
- Make doctor’s appointment [ ]
- Public Health Nurse referral [ ]
- Family aware [ ]

**Laboratory/Screening results**

- Hearing screen [ ]
  - Previously done [ ] Date completed ______________________
  - Previously done [ ] Date completed ______________________

- Vision screen [ ]
  - Previously done [ ] Date completed ______________________
  - Previously done [ ] Date completed ______________________

- Cholesterol [ ]

- Hyperlipidemia risk (if hx unknown consider screening) [ ]
  - Family Hx of depression [ ]
  - Family Hx of sudden death [ ]
  - Family Hx of depression [ ]
  - Family Hx of sudden death [ ]

**PPD / Anemia**

- PPD done (if exposure risk) [ ]
  - Date done ________ / ________ / ________
  - PPD result if done [ ]
  - PPD plan/comments ________________________________

  - PPD result if done [ ]
  - Date done ________ / ________ / ________
  - Hgb/Hct ordered / date done ________ / ________ / ________
  - Hgb/Hct result: Hgb ________ Hct ________
  - Hgb/Hct plan/comments ________________________________

- If sexually active discuss birth control, pregnancy, and STD risk.

- Chlamydia test ordered [ ]
  - Date done ________ / ________ / ________
  - Not indicated [ ]
  - Previously done [ ] Results ________________________________
  - Chlamydia plan/comments ________________________________

- Heavy menses, extreme weight loss, etc. ________________________________

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**Examiner’s Signature** ____________________________

**Date** ___________