

Name: \_\_\_\_\_ FMP/SSN last four: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Appointment Date: \_\_\_\_\_ Contact Number: \_\_\_\_\_

## 12-18 YEAR VISIT

Do you have any specific concerns today? \_\_\_\_\_

Any recent ER visits?  Yes  No When: \_\_\_\_\_ Reason: \_\_\_\_\_

**\*\*\*\*\*(Please complete information below: If filled out before, list only changes since the last visit.)\*\*\*\*\***

Chronic Medical Conditions (Circle all that apply)	Surgeries/Hospitalizations (Dates)	Family History (biological siblings, parents, grandparents)	Medicines (PLEASE INCLUDE DOSAGE)
Hay fever/Allergies Asthma ADHD Overweight Chronic ear infections Other:		Hay fever/Allergies Asthma Other:	<u>(Include over-the-counter meds, Tylenol, Motrin, vitamins, herbal supplements):</u>          Do you ever forget to take your medications? <input type="checkbox"/> Yes <input type="checkbox"/> No

**Check if anyone in the family has had:**

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Sudden Death     | <input type="checkbox"/> Hypertrophic Cardiomyopathy | <input type="checkbox"/> Genetic or Metabolic Disease |
| <input type="checkbox"/> High Cholesterol        | <input type="checkbox"/> Long QT syndrome | <input type="checkbox"/> Obesity                     | <input type="checkbox"/> Mental Illness               |
| <input type="checkbox"/> Heart attack < 50 years |   | <input type="checkbox"/> Diabetes                    |   |

Please list any known allergies you have (medication, food, latex) \_\_\_\_\_

Are you enrolled in the Exceptional Family Member Program (EFMP/Q-coded)?  Yes  No

Is your sponsor currently deployed?  Yes  No Is this visit deployment related?  Yes  No

Is either of the child's parents on PRP status?  Yes  No

Are your immunizations up to date?  Yes  No  Unsure

Who do you live with? \_\_\_\_\_

Do you attend:  DOD school  British School  Home-schooled (Grade: \_\_\_\_\_)  Aftercare **Concerns?**  Yes  No

Do you or anyone in your family smoke?  Yes  No

Do you feel safe at home?  Yes  No

What is your preferred method for learning:  Verbal  Written  Visual  Other: \_\_\_\_\_

Preferred language:  English  Other: \_\_\_\_\_

Are there cultural or religious considerations that affect your healthcare?  Yes  No \_\_\_\_\_

**Check if you have a history of:**

- |                                      |   |   |
|--------------------------------------|---|---|
| <input type="checkbox"/> Trauma      | <input type="checkbox"/> Fractures                | <input type="checkbox"/> Fainting during exercise |
| <input type="checkbox"/> Head Trauma | <input type="checkbox"/> Chest pain or discomfort | <input type="checkbox"/> Exercise intolerance     |
| <input type="checkbox"/> Concussion  | <input type="checkbox"/> Palpitations             | <input type="checkbox"/> Headaches                |

**Diet History:**

Are you a picky eater?  Yes  No Does you usually eat large portions or multiple servings?  Yes  No

# of servings of fruits & vegetables per day? \_\_\_\_\_ # of times eating fast food per week? \_\_\_\_\_

Do you usually eat dinner with your family?  Yes  No Do you usually eat breakfast?  Yes  No

Drink milk?  Yes  No How many ounces per day? \_\_\_\_\_ What type of milk?  Whole  2%  1%  Skim

Drink juice?  Yes  No How many ounces per day? \_\_\_\_\_ Drink caffeinated beverages?  Yes  No Number/week? \_\_\_\_\_

**Exercise History:**

Do you get at least one hour of physical activity at least 5 times per week?  Yes  No Type of activity: \_\_\_\_\_


How many hours of exposure do you have to TV/video games/computer time per day? \_\_\_\_\_

Do you have a TV or internet in your bedroom?  Yes  No

How many hours of sleep do you get on an average night? \_\_\_\_\_

Circle if you have any concerns about the following: Bowel movements / Sleep problems / Bedwetting / Vision / Hearing

Females only (if applicable): Last menstrual period \_\_\_\_\_ Any concerns about your periods?  Yes  No

Weight		Visual Acuity: R 20/____ L 20/____ Both 20/____
Height		Pain: <input type="checkbox"/> Yes <input type="checkbox"/> No Location of Pain _____ 
BMI/ %		
BP		

HPI:  
H:  
E:  
A:  
D:  
S:  
S:  
S:

NE	Examination:	Normal	Abnormal
<input type="checkbox"/>	<b>General:</b>	<input type="checkbox"/> Active/Alert/WN/WD/NAD/ not dysmorphic	<input type="checkbox"/>
<input type="checkbox"/>	<b>Head/Neck:</b>	<input type="checkbox"/> NCAT, FROM, Neck supple, NI thyroid, NI lymph nodes	<input type="checkbox"/>
<input type="checkbox"/>	<b>Eyes:</b>	<input type="checkbox"/> PERRL, RR X2, nl corneal reflex, EOMI, no strabismus	<input type="checkbox"/>
<input type="checkbox"/>	<b>R ear:</b>	<input type="checkbox"/> TM gray/nl landmarks, nl pinna/ext ear canal	<input type="checkbox"/> Bulging/immobile/red
<input type="checkbox"/>	<b>L ear:</b>	<input type="checkbox"/> TM gray/nl landmarks, nl pinna/ext ear canal	<input type="checkbox"/> Bulging/immobile/red
<input type="checkbox"/>	<b>Nose:</b>	<input type="checkbox"/> Patent, No congestion/discharge	<input type="checkbox"/> Congested
<input type="checkbox"/>	<b>Oropharynx:</b>	<input type="checkbox"/> Pink, moist, no lesions <input type="checkbox"/> Teeth: NI, no signs of caries	<input type="checkbox"/>
<input type="checkbox"/>	<b>Lungs:</b>	<input type="checkbox"/> CTAB, no retractions, nl WOB	<input type="checkbox"/>
<input type="checkbox"/>	<b>CV:</b>	<input type="checkbox"/> RRR, no murmur, strong arterial pulses, cap refill < 2 sec	<input type="checkbox"/>
<input type="checkbox"/>	<b>Abd:</b>	<input type="checkbox"/> Soft, NT, no HSM, no masses, nl BS	<input type="checkbox"/>
<input type="checkbox"/>	<b>Ext/Spine:</b>	<input type="checkbox"/> NL, FROM, nontender, no edema, spine straight	<input type="checkbox"/>
<input type="checkbox"/>	<b>Skin:</b>	<input type="checkbox"/> No rash/skin lesions	<input type="checkbox"/>
<input type="checkbox"/>	<b>Female:</b>	<input type="checkbox"/> NI breasts/Tanner _____ <input type="checkbox"/> NI ext genitalia/Tanner _____	
<input type="checkbox"/>	<b>Male:</b>	<input type="checkbox"/> NI penis, NI scrotum, Testes down, Tanner _____, No hernia	
<input type="checkbox"/>	<b>Neuro:</b>	<input type="checkbox"/> NI tone/strength/DTRs/balance/gait <input type="checkbox"/> CN II-XII intact	<input type="checkbox"/>
<input type="checkbox"/>	<b>Musculoskeletal:</b>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<b>Other findings:</b>	<input type="checkbox"/>	<input type="checkbox"/>

**LABS/X-RAYS:**

- ASSESSMENT:**  Well teen: normal growth & development for age  
 Immunizations per clinic schedule  
 Optometry Referral  
 Sports Physical Form/Health Assessment form completed/returned


**PLAN:**

**F/U:** at next well visit at \_\_\_\_ years, sooner if parental or personal concerns

- Patient and/or parent verbalizes understanding of treatment and plan  Anticipatory guidance handout provided

- PREVENTION:**  Dental care  Safety  Bike Helmet  Seatbelts  Tobacco avoidance  Sun protection  
 Exercise  Nutrition  Media Time  Relationships

Signature: \_\_\_\_\_  
Date: \_\_\_\_\_  
Stamp: \_\_\_\_\_

<b>RECORDS MAINTAINED AT:</b> 		
PATIENT'S NAME (Last, First, Middle Initial)		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME		ORGANIZATION
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH