

Pediatric Worksheet 2 -18 year Acute & 11 to 18 year Well Child visit.

Name: _____ FMP and Sponsor Last Four: _____ / _____ Date: _____

(Patient Label)

If this is the **FIRST** time you are filling in this form, please complete **ALL** areas. If you have **ALREADY** completed it, please complete **SHADED** areas **ONLY**.

No Allergies Please list any allergies you have (drug, food, latex) _____

What is the reason for today's visit? _____

Clinic Use Only

BP	/	HT	Visual Acuity: R 20/____ L 20/____ Both 20/____
HR		WT	Pain: <input type="checkbox"/> Yes <input type="checkbox"/> No Location of Pain _____
RR		HC	
TEMP		SpO2	

(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) (Circle all that apply)	Family History – (Parents, grandparents, siblings, aunts, uncles) (PLEASE STATE WHOM)	Medicines (PLEASE INCLUDE DOSAGE)
<input type="checkbox"/> NO Medical Conditions <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Hayfever/Allergies <input type="checkbox"/> Other: _____	<input type="checkbox"/> NO History of Surgeries <input type="checkbox"/> Ear Tubes <input type="checkbox"/> Tonsillectomy <input type="checkbox"/> Adenoidectomy <input type="checkbox"/> Appendectomy <input type="checkbox"/> Circumcision <input type="checkbox"/> Other: _____	<input type="checkbox"/> Birth Defects <input type="checkbox"/> Deafness before Age 5 <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Post Partum Depression <input type="checkbox"/> Early or Sudden Death to include SIDS <input type="checkbox"/> Heart attack before age 50 <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Hypertrophic Cardiomyopathy <input type="checkbox"/> Long QT syndrome <input type="checkbox"/> Arrhythmias <input type="checkbox"/> Diabetes <input type="checkbox"/> Mental Illness <input type="checkbox"/> Alcohol or Substance Abuse <input type="checkbox"/> Genetic or Metabolic Disease <input type="checkbox"/> Other: _____	Please list all prescribed medications including supplements, herbals and vitamins obtained Over the Counter _____ _____ _____

Source of Medical Information: Mother Father Patient Other: _____

Any Hospitalizations, specialty care, or ER visits since your last appointment? No Yes: _____

Would you say your child's Overall Feeling of health is? Excellent Very Good Good Fair Poor

Are you or the patient currently in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid? Yes No Decline

Are your child's immunizations up to date? Yes Unsure No

Does your child have a chronic medical or behavioral health problem, and/or physical disability? No Yes

Is frequent follow-up support required for the above issues? No Yes

Does your child require early interventions or special education services? No Yes

Is your child enrolled in the Exceptional Family Member Program? No Yes

Is your child In Day-Care In Preschool In school GRADE: _____ Home-schooled GRADE: _____

Does anyone in the family smoke or is your child exposed to secondhand smoke? No Yes

Who does the Child Live With? Parents Mother Father Other(s): _____

Is Sponsor currently deployed: No Yes

Is this visit deployment related: No Yes

Does your child ride in a car with a car seat or seat belt? Yes No

Does your child ride a bike wearing a helmet? N/A Yes No

11. What is your preferred method for learning: Verbal Written Visual Hands-On Other: _____

Yes No - Do you or your child have learning/readiness needs?

Yes No - Are there cultural or religious considerations that affect your child's healthcare?

Yes No - Are you and your child enrolled in Secure Messaging/RelayHealth/MiCare?

****PLEASE PROVIDE A GOOD CONTACT NUMBER:** _____

(Please complete Questions on REVERSE SIDE OF DOCUMENT)

Complete YEARLY through age 6 years

- Yes No Unsure Does your child have a sibling or playmate with Hx of lead poisoning?
- Yes No Unsure Does your child live in or regularly visit a house or child care facility built before 1950?
- Yes No Unsure Does your child live in or regularly visit a house or child care facility built before 1978 that has peeling/chipping paint or has been renovated or remodeled within the past 6 months?

Complete YEARLY Tuberculosis Screening -

- Yes No Unsure Has a family member or contact had tuberculosis?
- Yes No Unsure Has a family member had a positive tuberculin skin test?
- Yes No Unsure Was your child born in a high-risk country (countries other than US, Canada, Australia, New Zealand, Western Europe)?
- Yes No Unsure Has your child traveled to a high risk country for more than one week (had contact with country residents)?

Drinks milk? Yes No Percentage: _____ How many ounces per day? _____
MARK ALL THAT APPLY: Bladder Trained Bowel Trained Currently Toilet Training Bowel or bladders concerns
 Sleep concerns, difficulties or disturbances. Unsure No Yes:
 Exercise: <1h active play per day >1h active play per day
 TV Time: = (internet, iPad, tablet, DVD, etc.) <2h per day TV/Screen Time
 >2h per day TV/Screen Time. (List items and time spent.)

Pre-teen/teen females only (if applicable): Last menstrual period _____ or Not Applicable
 How many days does her period last? _____ How many pads per day? _____

7 year to 10 year Well Child visit: Check all the following that apply to your child and age:

7-YEARS TO 8 YEARS	9 YEARS TO 10 YEARS
<input type="checkbox"/> Eats Health meals and snacks	<input type="checkbox"/> Eats Healthy Meals and Snacks
<input type="checkbox"/> Participates in an after school activity	<input type="checkbox"/> Participates in an after school activity
<input type="checkbox"/> Has Friends	<input type="checkbox"/> Has friends.
<input type="checkbox"/> Is vigorously active for 1 hour a day	<input type="checkbox"/> Is vigorously active for 1 hour a day
<input type="checkbox"/> Is doing well in school	<input type="checkbox"/> Has a caring/supportive family
<input type="checkbox"/> Does chores when asked	<input type="checkbox"/> Is doing well in school
<input type="checkbox"/> Gets along with family	<input type="checkbox"/> 7. Is getting chances to make own decisions
	<input type="checkbox"/> 8. Feels good about self
	<input type="checkbox"/> 9. Does an activity really well; describe:

(Patient 11 years and older complete information below and return to clinical staff)

Age 11 and older - Do you now or have you ever used tobacco products? No. Yes (provider will discuss privately)

Age 11 and older complete once a year.

Over the past 2 weeks, how often have you been bothered by any of the following problems?

- 1) Little interest or pleasure in doing things?
 Not at all Several days More than half the days Nearly every day
- 2) Feeling down, depressed, irritable or hopeless?
 Not at all Several days More than half the days Nearly every day

Patients 11 years and older

Are you thinking about hurting yourself? (Suicide) No Yes
 Are you thinking about hurting others? (Homicide) No Yes

------(CLINIC Use Only)-----

Attach Pediatric Symptom Checklist Youth (PSC-Y) if completed

Attach SCARED screener if completed

HEALTH	CHRONOLOGICAL RECORD OF MEDICAL CARE
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DATE _____ SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (*Sign each entry*)

AHLTA was not accessible during this patient visit. Reviewed note & agree with the reverse side _____ (*Provider Initial*)

VISIT FOR: : Well Child Visit 7 Years 8 Years 9 Years 10 Years 11-18 Years
 Acute: Follow-up:

HPI:

ROS: Check only symptoms that may apply to today's visit.

<input type="checkbox"/> Fever	<input type="checkbox"/> Vision Problems	<input type="checkbox"/> Chest Pain
<input type="checkbox"/> Headache	<input type="checkbox"/> Hearing Concerns	<input type="checkbox"/> Emotional Lability
<input type="checkbox"/> Nasal Congestion	<input type="checkbox"/> Snoring	<input type="checkbox"/> Tics
<input type="checkbox"/> Nasal Discharge	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Recent Unintentional Wt. Loss
<input type="checkbox"/> Earache	<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Trouble Falling Asleep
<input type="checkbox"/> Pulling at the Ear(s)	<input type="checkbox"/> Urinary Habits Change	<input type="checkbox"/> Sleep Disturbance
<input type="checkbox"/> Eyes Discharge	<input type="checkbox"/> Change in Bowel Habits	<input type="checkbox"/> Feels Overweight
<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Feels underweight
<input type="checkbox"/> Cough	<input type="checkbox"/> Limb Pain	<input type="checkbox"/> Feels tired
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Syncope	<input type="checkbox"/> Chest pain with exertion
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Dyspnea with exertion
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Wheezing- worse with a cold	<input type="checkbox"/> Syncope with exercise
<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Cough with exercise	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Decreased Appetite	<input type="checkbox"/> Nighttime Cough	<input type="checkbox"/> Limb numbness
<input type="checkbox"/> Rash	<input type="checkbox"/> Daytime Cough	

NE	Examination:	Normal	Abnormal
<input type="checkbox"/>	General:	<input type="checkbox"/> Active/Alert/WN/WD/NAD/ not dysmorphic	<input type="checkbox"/>
<input type="checkbox"/>	Head/Neck:	<input type="checkbox"/> NCAT/AFOF/neck supple	<input type="checkbox"/>
<input type="checkbox"/>	Eyes:	<input type="checkbox"/> EOMI, RR X2, nl corneal reflex <input type="checkbox"/> no strabismus	<input type="checkbox"/>
<input type="checkbox"/>	R ear:	<input type="checkbox"/> nl pinna/ext ear canal <input type="checkbox"/> TM gray/nl landmarks	<input type="checkbox"/> Bulging/immobile/red
<input type="checkbox"/>	L ear:	<input type="checkbox"/> nl pinna/ext ear canal <input type="checkbox"/> TM gray/nl landmarks	<input type="checkbox"/> Bulging/immobile/red
<input type="checkbox"/>	Nose:	<input type="checkbox"/> Patent, No congestion/discharge	<input type="checkbox"/> Congested <input type="checkbox"/> Boggy mucosa
<input type="checkbox"/>	Oropharynx:	<input type="checkbox"/> Pink, moist <input type="checkbox"/> Tonsils normal	<input type="checkbox"/> Large tonsils
<input type="checkbox"/>	Lungs:	<input type="checkbox"/> CTAB, no retractions, nl WOB	<input type="checkbox"/> wheeze <input type="checkbox"/> retractions
<input type="checkbox"/>	CV:	<input type="checkbox"/> RRR, no murmur, strong femoral pulses, cap refill < 2 sec	<input type="checkbox"/> murmur
<input type="checkbox"/>	Abd:	<input type="checkbox"/> Soft, NT, no HSM, no masses, nl BS, no umbilical/inguinal hernia	<input type="checkbox"/>
<input type="checkbox"/>	Ext:	<input type="checkbox"/> NL, FROM, nontender, no cyanosis, no clubbing, no edema	<input type="checkbox"/>
<input type="checkbox"/>	Spine:	<input type="checkbox"/> Straight	<input type="checkbox"/> Scoliosis
<input type="checkbox"/>	Skin:	<input type="checkbox"/> Normal skin <input type="checkbox"/> no rash	<input type="checkbox"/> generalized dry skin
<input type="checkbox"/>	Neuro:	<input type="checkbox"/> Normal tone/strength/symmetry	<input type="checkbox"/>
<input type="checkbox"/>	Genitalia:	<input type="checkbox"/> NI female <input type="checkbox"/> NI male, Testes down B/L Tanner Stage: _____ <input type="checkbox"/> No hernia B/L	<input type="checkbox"/>
<input type="checkbox"/>	Other findings:	<input type="checkbox"/>	<input type="checkbox"/>

<input type="checkbox"/> CBC	<input type="checkbox"/> BMP	<input type="checkbox"/> Bilirubin (T/D)	<input type="checkbox"/> EKG
<input type="checkbox"/> Blood Cx	<input type="checkbox"/> CMP	<input type="checkbox"/> TsBill	<input type="checkbox"/> Xray _____
<input type="checkbox"/> UA	<input type="checkbox"/> Chol Panel	<input type="checkbox"/> Monospot	<input type="checkbox"/> CT _____
<input type="checkbox"/> Urine Cx	<input type="checkbox"/> HbA1c	<input type="checkbox"/> EBV Titers	
<input type="checkbox"/> Stool Cx	<input type="checkbox"/> TSH, T4	<input type="checkbox"/> Lead	
<input type="checkbox"/> CRP/ESR	<input type="checkbox"/> Iron Profile	<input type="checkbox"/> Other _____	

11year to 18 year Well Child HEADSS Assessment

Home

Education

Activities

Drugs

Sexuality

Suicide

Safety

ASSESSMENT/PLAN: : Well Child: normal growth & development for age

Treatments orders for this visit – Ensure Patients Name and last four on Front of Document:		
<input type="checkbox"/> Bicillin IM 600,000 Units (<27kg)	<input type="checkbox"/> Ear Irrigation Left -- Right	<input type="checkbox"/> EVALUATE FOR VACCINE UPDATE
<input type="checkbox"/> Bicillin IM 1.2 Million Units (>27kg)	<input type="checkbox"/> Saline Bulb Suction	
<input type="checkbox"/> Rocephin IM ___ mg		<input type="checkbox"/> NEB Tx: Albuterol ___ mg
<input type="checkbox"/> Decadron PO/IM ___ mg	<input type="checkbox"/> Flu Swab	<input type="checkbox"/> Neb TX: Atrovent ___ mg
<input type="checkbox"/> Solumedrol IM ___ mg	<input type="checkbox"/> RSV Swab	<input type="checkbox"/> Neb Tx: Pulmicort ___ mg
<input type="checkbox"/> Tylenol (PO) _____ mg	<input type="checkbox"/> Strep Screen/TCx	<input type="checkbox"/> Neb TX: Saline ___ ml
<input type="checkbox"/> Motrin (PO) _____ mg	<input type="checkbox"/> Tussin Swab	
<input type="checkbox"/> Benadryl PO ___ mg	<input type="checkbox"/> Dex	
<input type="checkbox"/> Zofran PO/IV 2mg / 4mg / 8mg	<input type="checkbox"/> Other: _____	
<input type="checkbox"/> IV Therapy _____	Rate: _____ Cath size: _____ Site: _____ Start _____ Stop _____	

Child's Name _____
 Today's Date _____
 Date of Birth _____

Record Number _____
 Filled out by _____

Pediatric Symptom Checklist

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions or learning, you may help your child get the best care possible by answering these questions. Please mark under the heading that best fits your child.

		Never (0)	Sometimes (1)	Often (2)
1. Complains of aches/pains	1	_____	_____	_____
2. Spends more time alone	2	_____	_____	_____
3. Tires easily, has little energy	3	_____	_____	_____
4. Fidgety, unable to sit still	4	_____	_____	_____
5. Has trouble with a teacher	5	_____	_____	_____
6. Less interested in school	6	_____	_____	_____
7. Acts as if driven by a motor	7	_____	_____	_____
8. Daydreams too much	8	_____	_____	_____
9. Distracted easily	9	_____	_____	_____
10. Is afraid of new situations	10	_____	_____	_____
11. Feels sad, unhappy	11	_____	_____	_____
12. Is irritable, angry	12	_____	_____	_____
13. Feels hopeless	13	_____	_____	_____
14. Has trouble concentrating	14	_____	_____	_____
15. Less interest in friends	15	_____	_____	_____
16. Fights with others	16	_____	_____	_____
17. Absent from school	17	_____	_____	_____
18. School grades dropping	18	_____	_____	_____
19. Is down on him or herself	19	_____	_____	_____
20. Visits doctor with doctor finding nothing wrong	20	_____	_____	_____
21. Has trouble sleeping	21	_____	_____	_____
22. Worries a lot	22	_____	_____	_____
23. Wants to be with you more than before	23	_____	_____	_____
24. Feels he or she is bad	24	_____	_____	_____
25. Takes unnecessary risks	25	_____	_____	_____
26. Gets hurt frequently	26	_____	_____	_____
27. Seems to be having less fun	27	_____	_____	_____
28. Acts younger than children his or her age	28	_____	_____	_____
29. Does not listen to rules	29	_____	_____	_____
30. Does not show feelings	30	_____	_____	_____
31. Does not understand other people's feelings	31	_____	_____	_____
32. Teases others	32	_____	_____	_____
33. Blames others for his or her troubles	33	_____	_____	_____
34. Takes things that do not belong to him or her	34	_____	_____	_____
35. Refuses to share	35	_____	_____	_____

Total score _____

Does your child have any emotional or behavioral problems for which she/he needs help? N Y

Are there any services that you would like your child to receive for these problems? N Y

If yes, what services? _____