

Name _____ FMP/SSN last four: _____ DOB: _____

Email Address : _____ Contact Phone Number: _____

12-18 YEAR VISIT

Do you have any specific concerns today? _____

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

Chronic Medical Conditions	Surgeries/Hospitalizations	Dates	Family History (biological siblings, parents, grandparents) (Circle all that apply)	Medicines (PLEASE INCLUDE DOSAGE)
Hayfever/allergies	Example Circumcision		Allergies	(Include over-the-counter meds, Tylenol, Motrin, vitamins, herbal supplements):
Asthma			Asthma	
ADHD			Diabetes	
Overweight			Heart Disease	
Chronic ear infections			Obesity	
Other:				

Check if anyone in the family has had:

- High Blood Pressure Sudden Death Heart attack < 50 years Mental Illness
- High Cholesterol Long QT syndrome Genetic or Metabolic Disease Hypertrophic Cardiomyopathy

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

Are your immunizations up to date? Yes No Unsure

Who do you live with? _____

Do you attend: Public/private school Home-schooled (Grade : _____)

Does 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: _____

Please See Reverse Side

RECORDS MAINTAINED AT:		
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

Ethnic Origin Filipino Hispanic Asian/Pacific Islander Southeast Asian Other Unknown Decline to Respond

Race Asian/Pacific Islander African American Caucasian Western Indian Other Unknown Decline to Respond

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

Diet History:

Current Diet Less Than 5 Servings a day Of Fruits and/or vegetables Yes No

Current Diet High in Fat Content and Includes High Fat Snacks Yes No

Current Diet High Fat and includes Frequent Fast Foods Yes No

Current Diet High Fat and Includes Fried Foods Yes No

Days a Week eating Breakfast _____ Days/week Having Dinner with Family _____

Eats Extra Large Portions Yes No High Sugar Beverages Yes No How many ounces per day? _____

Caffeinated Beverages Yes No How many per week? _____

Daily Milk Intake _____ ounces per day Type of milk? Whole 2% 1% Skim

Exercise History

Does 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 to TV/video games/computer time do you have per day? _____

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

Do you have a history of:

- Trauma Fractures Fainting during exercise
- Head Trauma Chest pain or discomfort Exercise intolerance
- Concussion Palpitations

In the past week, have you had:

Fever	Yes/No	Duration? _____	Cough	Yes/No	Duration? _____
Headache	Yes/No	Duration? _____	Wheezing	Yes/No	Duration? _____
Congestion	Yes/No	Duration? _____	Vomiting	Yes/No	Duration? _____
Runny nose	Yes/No	Duration? _____	Diarrhea	Yes/No	Duration? _____
Earache	Yes/No	Duration? _____	Abdominal pain	Yes/No	Duration? _____
Eye discharge	Yes/No	Duration? _____	Appetite Less	Yes/No	Duration? _____
Sore throat	Yes/No	Duration? _____	Rash	Yes/No	Duration? _____
			Other (describe) _____		

Females only (if applicable): Last menstrual period _____

FOR STAFF USE ONLY

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

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

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, FROM, Neck supple, NI thyroid, NI lymph nodes	<input type="checkbox"/>
<input type="checkbox"/>	Eyes:	<input type="checkbox"/> PERRL, RR X2, nl corneal reflex, EOMI, no strabismus	<input type="checkbox"/>
<input type="checkbox"/>	R ear:	<input type="checkbox"/> TM gray/nl landmarks, nl pinna/ext ear canal	<input type="checkbox"/> Bulging/immobile/red
<input type="checkbox"/>	L ear:	<input type="checkbox"/> TM gray/nl landmarks, nl pinna/ext ear canal	<input type="checkbox"/> Bulging/immobile/red
<input type="checkbox"/>	Nose:	<input type="checkbox"/> Patent, No congestion/discharge	<input type="checkbox"/> Congested
<input type="checkbox"/>	Oropharynx:	<input type="checkbox"/> Pink, moist, no lesions <input type="checkbox"/> Teeth: NI, no signs of caries	<input type="checkbox"/>
<input type="checkbox"/>	Lungs:	<input type="checkbox"/> CTAB, no retractions, nl WOB	<input type="checkbox"/>
<input type="checkbox"/>	CV:	<input type="checkbox"/> RRR, no murmur, strong arterial pulses, cap refill < 2 sec	<input type="checkbox"/>
<input type="checkbox"/>	Abd:	<input type="checkbox"/> Soft, NT, no HSM, no masses, nl BS	<input type="checkbox"/>
<input type="checkbox"/>	Ext/Spine:	<input type="checkbox"/> NL, FROM, nontender, no edema, spine straight	<input type="checkbox"/>
<input type="checkbox"/>	Skin:	<input type="checkbox"/> No rash/skin lesions	<input type="checkbox"/>
<input type="checkbox"/>	Female:	<input type="checkbox"/> NI breasts/Tanner _____ <input type="checkbox"/> NI ext genitalia/Tanner _____	
<input type="checkbox"/>	Male:	<input type="checkbox"/> NI penis, NI scrotum, Testes down, Tanner _____, No hernia	
<input type="checkbox"/>	Neuro:	<input type="checkbox"/> NI tone/strength/DTRs/balance/gait <input type="checkbox"/> CN II-XII intact	<input type="checkbox"/>
<input type="checkbox"/>	Musculoskeletal:	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Other findings:	<input type="checkbox"/>	<input type="checkbox"/>

LABS/X-RAYS:

ASSESSMENT: Well teen: normal growth & development for age
 Immunizations per clinic schedule

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:

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