

# New Jersey: Early and Periodic Screening, Diagnosis and Treatment Exam

## CHILDHOOD: 12 YEARS

DATE: \_\_\_\_\_

Child's Name:	Date of Birth:
Allergies:	Current Medications:
Illnesses/Accidents/Problems/Concerns since birth:	

**Recommend practitioner have individual consultation with adolescent**

<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>	
<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
<input type="checkbox"/>	<input type="checkbox"/>	I have someone I can talk to	<input type="checkbox"/>	<input type="checkbox"/>	I get some physical activity every day
<input type="checkbox"/>	<input type="checkbox"/>	I have one or more close friends	<input type="checkbox"/>	<input type="checkbox"/>	I get enough sleep; _____ hours per night

WEIGHT KG/LB PERCENTILE:	HEIGHT CM/FT/INS PERCENTILE:	BLOOD PRESSURE:	Diet: _____
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Review of Systems       Review of Family History

\_\_\_\_\_

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<input type="checkbox"/> Vitamin Supplement	<input type="checkbox"/> Menarche
<input type="checkbox"/> Fluoride Supplement	<input type="checkbox"/> Hgb/Hct
<input type="checkbox"/> Dental Referral	
<input type="checkbox"/> TB Test (if high risk factors present)	
<input type="checkbox"/> Cholesterol Screening (for high risk children)	
<input type="checkbox"/> Review Immunization Record	
<input type="checkbox"/> Dipstick Urinalysis	

Elimination: \_\_\_\_\_

Sleep: \_\_\_\_\_

Other: \_\_\_\_\_

<b>Screening</b>	<b>N</b>	<b>A</b>	
Hearing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Development	<input type="checkbox"/>	<input type="checkbox"/>	_____
Behavior	<input type="checkbox"/>	<input type="checkbox"/>	_____
Social/Emotional	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Health Education/Anticipatory Guidance: (CHECK ALL COMPLETED)**

<input type="checkbox"/> Nutrition	<input type="checkbox"/> Oral Health Care
<input type="checkbox"/> Development	<input type="checkbox"/> Parenting Issues
<input type="checkbox"/> Regular Physical Activities	<input type="checkbox"/> After School Supervision
<input type="checkbox"/> Seat Belt	<input type="checkbox"/> Adequate Sleep
<input type="checkbox"/> Safety	<input type="checkbox"/> Helmets
<input type="checkbox"/> Passive Smoke/Smoking	<input type="checkbox"/> School Issues
<input type="checkbox"/> Violence Prevention	<input type="checkbox"/> Firearm Safety
<input type="checkbox"/> Sexual Behavior	<input type="checkbox"/> Drugs/Alcohol
<input type="checkbox"/> Injury Prevention	<input type="checkbox"/> Puberty
<input type="checkbox"/> Acne	<input type="checkbox"/> Menarche
<input type="checkbox"/> Limit TV	

Other: \_\_\_\_\_

<b>Physical</b>	<b>N</b>	<b>A</b>		<b>N</b>	<b>A</b>	
General Appearance	<input type="checkbox"/>	<input type="checkbox"/>	Lungs	<input type="checkbox"/>	<input type="checkbox"/>	
Skin	<input type="checkbox"/>	<input type="checkbox"/>	Chest	<input type="checkbox"/>	<input type="checkbox"/>	
Head	<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular/Pulses	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	
Ears	<input type="checkbox"/>	<input type="checkbox"/>	Genitalia	<input type="checkbox"/>	<input type="checkbox"/>	
Nose	<input type="checkbox"/>	<input type="checkbox"/>	Spine	<input type="checkbox"/>	<input type="checkbox"/>	
Oropharynx/Teeth	<input type="checkbox"/>	<input type="checkbox"/>	Extremities	<input type="checkbox"/>	<input type="checkbox"/>	
Neck	<input type="checkbox"/>	<input type="checkbox"/>	Neurological	<input type="checkbox"/>	<input type="checkbox"/>	
Nodes	<input type="checkbox"/>	<input type="checkbox"/>	Gait	<input type="checkbox"/>	<input type="checkbox"/>	
Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	Sexual Maturity Rating	<input type="checkbox"/>	<input type="checkbox"/>	

**Describe findings:**

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**Assessment:**

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**Diagnosis:**

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**Treatment Plan:**

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\_\_\_\_\_

**REFERRALS:**

\_\_\_\_\_

\_\_\_\_\_

**IMMUNIZATIONS:**  given (see VFC Form)  up to date

**NEXT VISIT: 13 YEARS OF AGE**

Health Provider Signature: \_\_\_\_\_