AmeriChoice AMERIGROUP Health Net Horizon NJ Health UHP other__________________(08/04)

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

ADOLESCENCE: 13 YEARS

DATE:

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

Recommend practitioner have individual consultation with adolescent

Yes	No		Yes	No	
☐	☐	I eat breakfast every day	☐	☐	I am happy with how I am doing in school and/or work
☐	☐	I have someone I can talk to	☐	☐	I get some physical activity every day
☐	☐	I have questions about sexuality	☐	☐	I get enough sleep;____________ hours per night

WEIGHT KG/LB PERCENTILE:	HEIGHT CM/FT/INS PERCENTILE:	BLOOD PRESSURE:

☐ Review of Systems ☐ Review of Family History

____
____
____
____

Screening

	N	A	
Hearing	☐	☐	______________________
Vision	☐	☐	______________________
Development	☐	☐	______________________
Behavior	☐	☐	______________________
Social/Emotional	☐	☐	______________________

Physical	N	A		N	A
General Appearance	☐	☐	Lungs	☐	☐
Skin	☐	☐	Chest	☐	☐
Head	☐	☐	Cardiovascular/Pulses	☐	☐
Eyes	☐	☐	Abdomen	☐	☐
Ears	☐	☐	Genitalia	☐	☐
Nose	☐	☐	Spine	☐	☐
Oropharynx/Teeth	☐	☐	Extremities	☐	☐
Neck	☐	☐	Neurological	☐	☐
Nodes	☐	☐	Gait	☐	☐
Mental Health	☐	☐	Sexual Maturity Rating	☐	☐

Describe findings:

____
____
____
____
____
____
____
____
____

Diet:____

☐ Dental Referral
☐ Fluoride Supplement
☐ Vitamin Supplement
☐ TB Test (if high risk factors present)
☐ Cholesterol Screening (for high risk children)
☐ Review Immunization Record
☐ Dipstick Urinalysis
☐ Menarche
☐ Hgb/Hct

Elimination: ______________________________________
Sleep: ______________________________________
Other: ______________________________________

Health Education/Anticipatory Guidance:
(CHECK ALL COMPLETED)

☐	Nutrition/Weight Control	☐	Oral Health Care
☐	Body Image	☐	Adequate Sleep
☐	Development	☐	Seat Belt
☐	Helmets	☐	Passive Smoke/Smoking
☐	Regular Physical Activity	☐	Abstinence/Sex Education
☐	Suicide/Depression	☐	Drugs/Alcohol
☐	Self Exam	☐	Injury Prevention/Safety
☐	STD/HIV/AIDS	☐	Peer Pressure
☐	School Issues	☐	Acne
☐	Fire Arm Safety	☐	Menarche
☐	After School Supervision	☐	Limit TV

Other: ______________________________________

Assessment:

____
____
____

Diagnosis:

____

Treatment Plan:

____
____
____

REFERRALS:

____
____
____

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

NEXT VISIT: 14 YEARS OF AGE

Health Provider Signature: