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

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

ADOLESCENCE: 14 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
☐ Body Image
☐ Development
☐ Helmets
☐ Regular Physical Activity
☐ Suicide/Depression
☐ Self Exam
☐ STD/HIV/AIDS
☐ School Issues
☐ Fire Arm Safety
☐ After School Supervision
☐ Oral Health Care
☐ Adequate Sleep
☐ Seat Belt
☐ Passive Smoke/Smoking
☐ Abstinence/Sex Education
☐ Drugs/Alcohol
☐ Injury Prevention/Safety
☐ Peer Pressure
☐ Acne
☐ Limit TV

Other: _____

Assessment:

_____

_____

_____

Diagnosis:

_____

Treatment Plan:

_____

_____

_____

REFERRALS:

_____

_____

_____

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

NEXT VISIT: 15 YEARS OF AGE

Health Provider Signature: