

Name _____
Date of Birth _____
Chart No. _____

10-11 Year Male

Date _____ Time _____
Actual Age _____ Weight _____ lb _____ oz. Height _____ in. BMI _____
Temp _____ Pulse _____ Resp _____ BP _____ Pain Score (0 – 5) _____

☐ Environmental Screen ☐ Growth chart plotted

Nutrition: ☐ Vitamins ☐ Fluoride

Adverse Reactions (drug allergies): ☐ Yes* _____ ☐ No *If yes, also list on Patient Problem Summary in front of chart.

☐ Parent section reviewed? ☐ Parent's concerns addressed

☐ Immunizations current (copy in chart) ☐ Off Schedule ☐ Parental Refusal Explain _____

Problems: _____

For patients over the age of 6, do they feel safe at home? ☐ Yes ☐ No

Current Medications: ☐ None or list medications below.

Name	Dose	Frequency

Nurse's Signature

X

Physical: Check (☒) if normal. Circle if abnormal and describe.

☐ General Appearance

☐ Head/Face/Neck

☐ Eyes

☐ ENMT

☐ Respiratory

☐ Chest

☐ CV

☐ Abdomen

☐ Genitalia

☐ Skin

☐ Lymph nodes

☐ Extremities

☐ Musculoskeletal

☐ Back

☐ Neuro

☐ Psych

☐ Suicide Risk Assessment

Anticipatory Guidance: ☐ School ☐ Nutrition ☐ Tobacco ☐ Alcohol ☐ Drugs ☐ Guns/trigger locks ☐ Initiated PSC-17
☐ Car Safety ☐ Educational handouts ☐ Medication Education (if applicable) ☐ Immunization Information ☐ Sex Education

Assessment: _____

Plan: ☐ Tdap ☐ MCV4 ☐ HPV ☐ Flu ☐ Hgb (If necessary _____ value) ☐ Counseled

☐ Urine Screen (if necessary) ☐ UTO ☐ WNL

☐ Hearing Objective: Pass _____ Fail _____ ☐ Vision Objective: Right _____ Left _____ ☐ Glasses/contacts

☐ Color Perception (if necessary) Pass ____ Fail ____

☐ Other _____

☐ Interpretive Conference Conducted Return _____

☐ Parent/guardian instructed to keep **Current Medication List** to share with other providers and for emergencies. **INITIALS** _____

☐ Parent/guardian verbalized understanding the **Plan of Care**. **INITIALS** _____

Physician/Practitioner's Signature

X

Date

/ /

Time

AM/PM

:

Parent/Patient Section 10-11 Year Male

SECTION TO BE COMPLETED BY PARENT

Personal/Social History

Are you CONCERNED about your child's...
 (check appropriate box for each question)

- | | Yes | No |
|-------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. Overall progress in school? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Happiness, self esteem, self confidence? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Ability to sit still, listen or participate? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. School attendance? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Physical development? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Social development (lack of friends, excessive shyness, withdrawal from family)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Behavioral development (temper outbursts, aggression, violence)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Emotional development (mood changes, anxiety, depression) ? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Eating habits, weight loss, loss of energy, sleep habits? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Recurrent ear, sinus or throat infections, nosebleeds? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Chest pain, shortness of breath, or irregular heartbeat? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Frequent colds, cough, wheezing, recurrent bronchitis? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Abdominal pain, vomiting, diarrhea, constipation? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Urinary control, bed wetting, urinary infections? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Joint pain, stiffness, swelling, muscle pain, weakness? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Birthmarks, skin rashes, itching, nail or hair problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Recurrent headaches, dizziness, tics, weak, seizures? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Mood changes, sadness, nervous problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Excessive thirst or hunger, increased urination, weight loss? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Paleness, anemia, easy bruising, swollen glands? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Milk, food or drug allergies, recurrent infections? | <input type="checkbox"/> | <input type="checkbox"/> |

Environmental Screening

Does your child....

- | | Yes | No |
|-----------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 22. Exercise on a regular basis? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Use a helmet skating and biking? | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Use a seat belt, ride in the back? | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Do you counsel him about avoiding the use of alcohol, tobacco, drugs and inhalants? | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Are there guns in the house? | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Does anyone in the household smoke? | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Do you have a swimming pool? | <input type="checkbox"/> | <input type="checkbox"/> |

History Update

- | | Yes | No |
|--------------------------------------------------------------------|--------------------------|--------------------------|
| 29. Has there been a change in your child's medical history? | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Has there been a change in your child's family medical history | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Change in household situation? | <input type="checkbox"/> | <input type="checkbox"/> |

Parent Comments (Please Print)

- | | Yes | No |
|------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other | | |
| 32. Do you have any concerns you wish to discuss? | <input type="checkbox"/> | <input type="checkbox"/> |

Signature

X

Date MM/DD/YY

/ /

Time 00:00 AM/PM

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