

Name _____
Date of Birth _____
Chart No. _____

16-18 Year Female

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.
☐ Patient section reviewed? ☐ Patient'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

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

Nurse's Signature X	
<input type="checkbox"/> General Appearance	
<input type="checkbox"/> Head/Face/Neck	
<input type="checkbox"/> Eyes	
<input type="checkbox"/> ENMT	
<input type="checkbox"/> Respiratory	
<input type="checkbox"/> Chest	
<input type="checkbox"/> CV	
<input type="checkbox"/> Abdomen	
<input type="checkbox"/> Genitalia	
<input type="checkbox"/> Skin	
<input type="checkbox"/> Lymph nodes	
<input type="checkbox"/> Extremities	
<input type="checkbox"/> Musculoskeletal	
<input type="checkbox"/> Back	
<input type="checkbox"/> Neuro	
<input type="checkbox"/> Psych	<input type="checkbox"/> Suicide Risk Assessment

Anticipatory Guidance: ☐ Exercise ☐ Sex Education ☐ Tobacco ☐ Alcohol ☐ Drugs ☐ Safety ☐ Initiated PSC-17
☐ Driving ☐ Guns/trigger locks ☐ Nutrition ☐ Educational handouts ☐ Medication Education (if applicable)
Assessment: Sexually Active Yes ____ No ____ ☐ Contraceptive used LMP _____ Gravida _____ Para _____

Plan: ☐ 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 ____
 If sexually active, ☐ Pap test, screen for: ☐ Chlamydia ☐ Gonorrhea
☐ 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 ____ : ____
---	-----------------------------------	----------------------------------

Patient Section 16-18 Year Female

SECTION TO BE COMPLETED BY PATIENT

Personal/Social History

Are you CONCERNED about...

(check appropriate box for each question)

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. School/work: (circle) grades, motivation, concentration, completing assignments? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Your breasts, menses, pelvic pain, vaginal discharge? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Sexual issues: (circle) sexual orientation, sexually transmitted diseases, AIDS/HIV, other? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Eating habits, weight loss, loss of energy, sleep habits? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Recurrent ear, sinus or throat infections, nosebleeds? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Chest pain, shortness of breath, or irregular heartbeat? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Frequent colds, cough, wheezing, recurrent bronchitis? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Abdominal pain, vomiting, diarrhea, constipation? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Urinary control, bed wetting, urinary infections? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Joint pain, stiffness, swelling, muscle pain, weakness? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Birthmarks, skin rashes, itching, nail or hair problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Recurrent headaches, dizziness, tics, weak, seizures? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Mood changes, sadness, nervous problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Excessive thirst or hunger, increased urination, weight loss? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Paleness, anemia, easy bruising, swollen glands? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Milk, food or drug allergies, recurrent infections? | <input type="checkbox"/> | <input type="checkbox"/> |

Environmental Screening

- | | Yes | No |
|---|--------------------------|--------------------------|
| 17. Have you had a pelvic examination?
Approx. date _____ Pap test _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. When was your last menstrual cycle? _____ | | |
| 19. Are you sexually active now? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, do you always use a condom? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Do you use cigarettes, smokeless tobacco? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Do you drink alcohol? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, do you drink: <input type="checkbox"/> beer <input type="checkbox"/> wine <input type="checkbox"/> liquor
<input type="checkbox"/> rarely <input type="checkbox"/> weekly <input type="checkbox"/> daily # of drinks _____ | | |
| 22. Have you been drunk in the past month? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Do you ever drive a vehicle when drinking? | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Do you ever use recreational drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Do you always use a seatbelt when in a car? | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Are there guns in the house? | <input type="checkbox"/> | <input type="checkbox"/> |

History Update

- | | Yes | No |
|---|--------------------------|--------------------------|
| 27. Has there been a change in your medical history? | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Has there been a change in your family medical history? | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Has there been a change in your household situation? | <input type="checkbox"/> | <input type="checkbox"/> |

Comments (Please Print)

- | | Yes | No |
|---|--------------------------|--------------------------|
| 30. 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

: