

Patient Name:

FMP and Sponsor SSN last four:

Date of visit: Date of Birth:

12-18 YEAR VISIT

Do you have any specific concerns today? _____

(Please complete information below: If filled out before, list only changes since the last visit.)

Chronic Medical Conditions (Circle all that apply)	Surgeries/Hospitalizations (Dates)	Family History (biological siblings, parents, grandparents)	Medicines (PLEASE INCLUDE DOSAGE)
Hay fever/allergies Asthma ADHD Overweight Chronic ear infections Other:		Hay fever/Allergies Asthma Other:	(Include over-the-counter meds, Tylenol, Motrin, vitamins, herbal supplements): Do you ever forget to take these medications? <input type="checkbox"/> Yes <input type="checkbox"/> No

Please list any known **allergies** your child has (drug, food, latex) _____

Check if anyone in the family has had:

- High Blood Pressure Sudden Death Long QT syndrome Diabetes
- High Cholesterol Hypertrophic Cardiomyopathy Genetic or Metabolic Disease
- Heart attack before age 50 Obesity Mental Illness

Are you enrolled in the Exceptional Family Member Program (EFMP/Q-coded)? Yes No

Is your sponsor currently deployed? Yes No Is this visit **deployment** related? Yes No

Source of Medical Information: Patient Mother Father Other: _____

Are your immunizations up to date? Yes No Unsure

Who do you live with? _____

Do you attend: Public/private school Home-schooled Grade: _____

Does anyone in the family smoke or is your child exposed to secondhand smoke? Yes No

Instructions for Patient Understood by Caregiver/Patient? Yes No

What is your preferred method for learning: Verbal Written Other: _____

Preferred language: English Other: _____

Are there cultural or religious considerations that affect your healthcare? No Yes _____

Please provide a good contact phone number: _____

----- Additional Hx/Prevention -----

Check if you have had a history of:

- Trauma Stress Heart Murmur Fainting during exercise
- Head Trauma Drug Use High Blood Pressure Asthma
- Concussion Alcohol Use Chest pain or discomfort Headache Syndromes
- Fractures Congenital Heart Disease Palpitations Seizure Disorder

Diet History:

Are you a picky eater? Yes No Servings of fruits and vegetables per day? ____ # of times per week eating fast food? ____

Do you usually eat dinner as a family? Yes No Do you usually eat breakfast? Yes No

Do you eat extra large portions? Yes No Caffeinated beverages? Yes No How many per week? ____

Drink juice? Yes No Ounces per day? ____ Drink milk? Yes No Ounces per day? ____

Exercise History:

How much exposure to TV/video games/computer do you have per day? Less than 2 hours More than 2 hours

Do you get at least one hour of physical activity per day? Yes No Type of activity: _____

Do you have a TV or internet in your bedroom? Yes No

Pre-teen/teen females only (if applicable): Last menstrual period _____

Weight		Visual Acuity: R 20/____ L 20/____ Both 20/____
Height		Pain: <input type="checkbox"/> Yes <input type="checkbox"/> No Location of Pain _____
BP		 Imm UTD per AFCITA: <input type="checkbox"/> Yes <input type="checkbox"/> Technician Signature: _____

HPI:

NE	Examination:	Normal	Abnormal
<input type="checkbox"/>	General:	<input type="checkbox"/> Active/Alert/WN/WD/NAD/ not dysmorphic	<input type="checkbox"/>
<input type="checkbox"/>	Head/Neck:	<input type="checkbox"/> NCAT, FROM, Neck supple, NI thyroid, NI lymph nodes	<input type="checkbox"/>
<input type="checkbox"/>	Eyes:	<input type="checkbox"/> PERRL, RR X2, nl corneal reflex, EOMI, no strabismus	<input type="checkbox"/>
<input type="checkbox"/>	R ear:	<input type="checkbox"/> TM gray/nl landmarks, nl pinna/ext ear canal	<input type="checkbox"/> Bulging/immobile/red
<input type="checkbox"/>	L ear:	<input type="checkbox"/> TM gray/nl landmarks, nl pinna/ext ear canal	<input type="checkbox"/> Bulging/immobile/red
<input type="checkbox"/>	Nose:	<input type="checkbox"/> Patent, No congestion/discharge	<input type="checkbox"/> Congested
<input type="checkbox"/>	Oropharynx:	<input type="checkbox"/> Pink, moist, no lesions <input type="checkbox"/> Teeth: NI, no signs of caries	<input type="checkbox"/>
<input type="checkbox"/>	Lungs:	<input type="checkbox"/> CTAB, no retractions, nl WOB	<input type="checkbox"/>
<input type="checkbox"/>	CV:	<input type="checkbox"/> RRR, no murmur, strong arterial pulses, cap refill < 2 sec	<input type="checkbox"/>
<input type="checkbox"/>	Abd:	<input type="checkbox"/> Soft, NT, no HSM, no masses, nl BS	<input type="checkbox"/>
<input type="checkbox"/>	Ext/Spine:	<input type="checkbox"/> NL, FROM, nontender, no edema, spine straight	<input type="checkbox"/>
<input type="checkbox"/>	Skin:	<input type="checkbox"/> No rash/skin lesions	<input type="checkbox"/>
<input type="checkbox"/>	Female:	<input type="checkbox"/> NI breasts/Tanner ____ <input type="checkbox"/> NI ext genitalia/Tanner ____	
<input type="checkbox"/>	Male:	<input type="checkbox"/> NI penis, NI scrotum, Testes down, Tanner ____, No hernia	
<input type="checkbox"/>	Neuro:	<input type="checkbox"/> NI tone/strength/DTRs/balance/gait <input type="checkbox"/> CN II-XII intact	<input type="checkbox"/>
<input type="checkbox"/>	Other findings:	<input type="checkbox"/>	<input type="checkbox"/>

LABS/X-RAYS:

ASSESSMENT: Well child: normal growth & development for age

PLAN: Fluoride supplementation (as needed locally)
 Immunizations per clinic schedule

F/U: at next well child visit at ____ years, sooner if parental concerns

Patient and/or parent verbalizes understanding of treatment and plan Anticipatory guidance handout provided

PREVENTION: Dental visits Safety/Falls Bike Helmet Booster Seat Tobacco avoidance Sun safety
 Exercise Nutrition Media Time

Signature: _____

Date:

Stamp:

RECORDS MAINTAINED AT: 		
PATIENT'S NAME (Last, First, Middle Initial)		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME		ORGANIZATION
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH