

Naval Hospital Oak Harbor Prime Health Center
Adolescent (13yr-18yr) Well Child Visit

Date: _____
Time: _____

Provider Note

Interval History:

Review of Systems:

Menarche:

Past Medical History:

Medications:

Allergies:

Immunizations:

Family Relations:

School/Social Issues:

School Performance/Career Plans

Tobacco/Alcohol/Drug Use:

After School Activities:

Work:

Friendships:

Sexual Activity:

Contraception:

Mood:

Physical Exam

Weight: _____ kg _____ lb _____ %ile

Length: _____ cm _____ in _____ %ile

Body Mass Index: _____ kg/m² _____ %ile

Vital Signs N/A

Pain: _____ (0-10)

Temp: _____ HR: _____

RR: _____ BP: _____

O2 Sat: _____

NI Abn

- | | | |
|--------------------------|--------------------------|---------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | General Appearance: |
| <input type="checkbox"/> | <input type="checkbox"/> | Head: |
| <input type="checkbox"/> | <input type="checkbox"/> | Eyes: |
| <input type="checkbox"/> | <input type="checkbox"/> | ENT: |
| <input type="checkbox"/> | <input type="checkbox"/> | Neck: |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest: |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart: |
| <input type="checkbox"/> | <input type="checkbox"/> | Abdomen: |
| <input type="checkbox"/> | <input type="checkbox"/> | Genitals: |
| <input type="checkbox"/> | <input type="checkbox"/> | Musculoskeletal: |
| <input type="checkbox"/> | <input type="checkbox"/> | Skin: |
| <input type="checkbox"/> | <input type="checkbox"/> | Neuro: |

Vision Screening

Right:

Left:

Assessment

Plan

Anticipatory Guidance

Labs: Urinalysis, CBC, Cholesterol, HIV

Immunizations: HepB, Td, Influenza

Other:

Follow-up:

Addressograph

Examiner's Signature/Name Stamp

**Adolescent (13yr-18yr) Well Child Visit
Parent Questionnaire**

1. How often does your child see the dentist? _____
2. Do you provide your child healthy food choices and nutritious snacks? Yes/No
3. Does your child brush and floss his/her teeth regularly? Yes/No
4. Does your child have any sleep problems? Yes/No
5. Are you concerned about your child's mood? Yes/No
6. Does your child exercise regularly? Yes/No
7. Do you try to regulate your child's television-watching (time, content)? Yes/No
8. Does your child have any responsibilities at home (chores)? Yes/No
9. Is there is a gun in the home? Yes/No
10. Does your home have working smoke detectors? Yes/No
11. Does your child wear a bicycle helmet when riding a bicycle, scooter, or skateboard? Yes/No
12. Does your child wear a seat belt in the car? Yes/No
13. Have you talked to your child about drunk driving? Yes/No
14. Do you help your child with his/her homework? Yes/No
15. Have you talked to your child about puberty/sexuality? Yes/No
16. Have you talked to your child about tobacco, alcohol, and drugs? Yes/No
17. Do you fear for the safety of yourself or members of your family? Yes/No
18. What questions do you have for your child's provider today?