

13 to 21 Year Child Health Check-Up Tracking Form

PLEASE PRINT

PERSONAL

Periodic Interperiodic Parent/Caregiver Request

NAME (Last)	(First)	ID	DATE OF BIRTH
DATE	AGE	ACCOMPANIED BY	RELATIONSHIP

INTERVAL HISTORY

PAST MEDICAL HISTORY WNL	<input type="checkbox"/> YES	<input type="checkbox"/> NO (IF NO, DESCRIBE)
DEVELOPMENTAL HISTORY WNL	<input type="checkbox"/> YES	<input type="checkbox"/> NO (IF NO, DESCRIBE)
BEHAVIORAL HEALTH STATUS WNL	<input type="checkbox"/> YES	<input type="checkbox"/> NO (IF NO, DESCRIBE)

NUTRITIONAL ASSESSMENT

WNL	<input type="checkbox"/> YES	<input type="checkbox"/> NO (IF NO, DESCRIBE)	<input type="checkbox"/> FLUORIDE	<input type="checkbox"/> REFERRED
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PHYSICAL EXAM

HEIGHT	WEIGHT	BLOOD PRESSURE
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Are the following normal?

	YES	NO	COMMENTS
Appearance			
Skin			
Head			
Eyes			
Ears			
Nose			
Mouth/Throat/Teeth/Gums			<input type="checkbox"/> DENTAL REFERRAL AGE 3 AND UP REQUIRED
Nodes			
Heart			
Lungs			
Abdomen			
Fem. Pulse			
Ext. Gen.			Tanner Staging:
Extremities			
Spine			
Neuro			
Other			

LAB TESTS

<input type="checkbox"/> Hgb/Hct _____ (9 mo, adolescent females & as indicated)	<input type="checkbox"/> OTHER (specify, as indicated)
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SENSORY SCREEN

NORMAL VISION? <input type="checkbox"/> YES <input type="checkbox"/> NO	RESULTS: RIGHT _____ LEFT _____ BOTH _____	NORMAL HEARING? <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL (RIGHT _____ LEFT _____)	<input type="checkbox"/> REFERRED
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DEVELOPMENT ASSESSMENT

IS DEVELOPMENT NORMAL FOR AGE AND CULTURE?
<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED

IMMUNIZATIONS

<input type="checkbox"/> CURRENT <input type="checkbox"/> DEFERRED <input type="checkbox"/> PROVIDED: LIST
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HEALTH EDUCATION, ANTICIPATORY GUIDANCE

<input type="checkbox"/> CAR/SEAT BELT SAFETY	<input type="checkbox"/> SEXUAL ED & STDs	<input type="checkbox"/> PHYSICAL ACTIVITY
<input type="checkbox"/> PREGNANCY PREVENTION	<input type="checkbox"/> NUTRITION	<input type="checkbox"/> COMM. AFFECTION
<input type="checkbox"/> MOTORCYCLE/ HELMET SAFETY	<input type="checkbox"/> SMOKING, ALCOHOL, DRUGS	
<input type="checkbox"/> SCHOOL PERFORMANCE	<input type="checkbox"/> BREAST OR TESTICULAR SELF-EXAM	

DIAGNOSIS:
PLAN:
SIGNATURE: