

PEDIATRIC CONTINUITY CLINIC
AMBULATORY CARE CENTER
MEDICAL COLLEGE OF GEORGIA
AUGUSTA, GEORGIA

DATE: _____

ADOLESCENT CHECK-UP

Weight: _____ : %: _____

Height: _____ : % _____

Pertinent Medical Interval History (Illnesses, medications, etc.):

BiHEADS (discuss confidentiality, parent alone, then patient alone):

Body Image (eating disorder/obesity):

Home: _____

Education: _____

Activities: _____

Drugs (street drugs, alcohol, tobacco): _____

CAGE: _____

Sex (abuse, protection against STD, pregnancy): _____

Suicide/safety: _____

GENERAL PHYSICAL EXAMINATION

BP: _____/_____

- Vision: R Eye: Near: _____; Far: _____; Both Eyes: _____

L Eye: Near: _____; Far: _____

- Hearing: R Ear: _____; L Ear: _____

Pain Scale _____; Pain Score _____; Location: _____; MD Notified: _____; Initials: _____

	Normal			Normal	
	Y	N		Y	N
General Appearance	_____	_____		_____	_____
HEENT	_____	_____		_____	_____
Neck	_____	_____	Extremities	_____	_____
Lungs	_____	_____	Genitalia (pelvic exam)	_____	_____
Heart	_____	_____	Gait	_____	_____
Abdomen	_____	_____	Neurological	_____	_____
Neck	_____	_____			

OTHER PERTINENT PHYSICAL FINDINGS:

ANTICIPATORY GUIDANCE: Adolescent

	YES	NO
Is there smoking in the house	_____	_____
Is there a smoke alarm on each level of the house	_____	_____
If guns are in the home are they locked up in a cabinet	_____	_____
Lead Poisoning risk factors:		
Home built before 1960	_____	_____
Has house built around then been renovated	_____	_____
Does a family member have increased exposure	_____	_____
Does a family member have elevated lead level	_____	_____
Did the child travel to the office in the a seat belt	_____	_____
Are plants and medications out of reach	_____	_____
Is child in day care	_____	_____
Is the child exposed to a swimming pool; if so, is it protected	_____	_____
Is there a family history of high cholesterol (> 250)	_____	_____
Is there a family history of early heart attack (pre-age 50)	_____	_____
Medications in house	_____	_____
Wears helmet when riding bike	_____	_____
Tuberculosis risk (family member with chronic cough)	_____	_____
Breast/testicle self-exam	_____	_____

IMPRESSIONS: 1. _____
2. _____
3. _____

MEDS: 1. _____
2. _____
3. _____

IMMUNIZATIONS: 1. _____ **Should have had the following:**
2. _____ **5 DTaP, 4 HIB, 2 MMR, 1 Varicella, 4 Polio**

LAB 1. _____ **PAP smear if sexually active, consider HIV**
2. _____ **Should consider the following tests:**
3. _____ **Hgb if menses heavy, cholesterol, UA, TB skin**

RETURN TO CLINIC: In the next two years

Continuity Clinic Resident: _____

Attending Note: _____

Signature of Attending: _____