AmeriChoice AMERIGROUP Health Net Horizon NJ Health UHP other_____(08/04)

# New Jersey: Early and Periodic Screening, Diagnosis and Treatment Exam

## CHILDHOOD: 11 YEARS

DATE:

| | |
|---|---|
| Child's Name: | Date of Birth: |
| Allergies: | Current Medications: |
| Illnesses/Accidents/Problems/Concerns since birth: | |

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| ☐ | ☐ | My child eats breakfast every day | ☐ | ☐ | My child seems rested when he/she awakens |
| ☐ | ☐ | My child is doing well in school | ☐ | ☐ | My child handles stress, anger, and frustration appropriately |
| ☐ | ☐ | My child has one or more close friends | ☐ | ☐ | My child gets some physical activity every day |

| WEIGHT KG/LB PERCENTILE: | HEIGHT CM/FT/INS PERCENTILE: | BLOOD PRESSURE: |
|---|---|---|
| | | |

☐ Review of Systems ☐ Review of Family History

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_____

### Screening

| | N | A | |
|---|---|---|---|
| Hearing | ☐ | ☐ | _____ |
| Vision | ☐ | ☐ | _____ |
| Development | ☐ | ☐ | _____ |
| Behavior | ☐ | ☐ | _____ |
| Social/Emotional | ☐ | ☐ | _____ |

### Physical

| | N | A | | N | A |
|---|---|---|---|---|---|
| General Appearance | ☐ | ☐ | Lungs | ☐ | ☐ |
| Skin | ☐ | ☐ | Chest | ☐ | ☐ |
| Head | ☐ | ☐ | Cardiovascular/Pulses | ☐ | ☐ |
| Eyes | ☐ | ☐ | Abdomen | ☐ | ☐ |
| Ears | ☐ | ☐ | Genitalia | ☐ | ☐ |
| Nose | ☐ | ☐ | Spine | ☐ | ☐ |
| Oropharynx/Teeth | ☐ | ☐ | Extremities | ☐ | ☐ |
| Neck | ☐ | ☐ | Neurological | ☐ | ☐ |
| Nodes | ☐ | ☐ | Gait | ☐ | ☐ |
| Mental Health | ☐ | ☐ | Sexual Maturity Rating | ☐ | ☐ |

**Describe findings:**

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_____

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Diet:_____

☐ Dental Referral
☐ Fluoride Supplement
☐ Vitamin Supplement
☐ TB Test (if high risk factors present)
☐ Cholesterol Screening (for high risk children)
☐ Review Immunization Record
☐ Dipstick Urinalysis
☐ Menarche
☐ Hgb/Hct

Elimination: _____

Sleep: _____

Other: _____

**Health Education/Anticipatory Guidance: (CHECK ALL COMPLETED)**

☐ Nutrition
☐ Development
☐ Regular Physical Activities
☐ Seat Belt
☐ Safety
☐ Passive Smoke/Smoking
☐ Violence Prevention
☐ Sexual Behavior
☐ Injury Prevention
☐ Acne
☐ Limit TV
☐ Oral Health Care
☐ Parenting Issues
☐ Child Care
☐ Adequate Sleep
☐ Helmets
☐ School Issues
☐ Firearm Safety
☐ Drugs/Alcohol
☐ Puberty
☐ Menarche

Other: _____

**Assessment:**

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_____

**Diagnosis:**

_____

**Treatment Plan:**

_____

_____

_____

**REFERRALS:**

_____

_____

_____

**IMMUNIZATIONS:** ☐ given (see VFC Form) ☐ up to date

## NEXT VISIT: 12 YEARS OF AGE

Health Provider Signature: