

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

ADOLESCENCE: 14 YEARS

DATE: _____

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

Recommend practitioner have individual consultation with adolescent

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	I eat breakfast every day	<input type="checkbox"/>	<input type="checkbox"/>	I am happy with how I am doing in school and/or work
<input type="checkbox"/>	<input type="checkbox"/>	I have someone I can talk to	<input type="checkbox"/>	<input type="checkbox"/>	I get some physical activity every day
<input type="checkbox"/>	<input type="checkbox"/>	I have questions about sexuality	<input type="checkbox"/>	<input type="checkbox"/>	I get enough sleep; _____ hours per night

WEIGHT KG/LB PERCENTILE: _____	HEIGHT CM/FT/INS PERCENTILE: _____	BLOOD PRESSURE: _____	Diet: _____
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☐ Review of Systems ☐ Review of Family History

☐ Dental Referral ☐ Menarche

☐ Fluoride Supplement ☐ Hgb/Hct

☐ Vitamin Supplement

☐ TB Test (if high risk factors present)

☐ Cholesterol Screening (for high risk children)

☐ Review Immunization Record

☐ Dipstick Urinalysis

Elimination: _____

Sleep: _____

Other: _____

Screening

	N	A	
Hearing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Development	<input type="checkbox"/>	<input type="checkbox"/>	_____
Behavior	<input type="checkbox"/>	<input type="checkbox"/>	_____
Social/Emotional	<input type="checkbox"/>	<input type="checkbox"/>	_____

Physical

	N	A		N	A	
General Appearance	<input type="checkbox"/>	<input type="checkbox"/>	Lungs	<input type="checkbox"/>	<input type="checkbox"/>	
Skin	<input type="checkbox"/>	<input type="checkbox"/>	Chest	<input type="checkbox"/>	<input type="checkbox"/>	
Head	<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular/Pulses	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	
Ears	<input type="checkbox"/>	<input type="checkbox"/>	Genitalia	<input type="checkbox"/>	<input type="checkbox"/>	
Nose	<input type="checkbox"/>	<input type="checkbox"/>	Spine	<input type="checkbox"/>	<input type="checkbox"/>	
Oropharynx/Teeth	<input type="checkbox"/>	<input type="checkbox"/>	Extremities	<input type="checkbox"/>	<input type="checkbox"/>	
Neck	<input type="checkbox"/>	<input type="checkbox"/>	Neurological	<input type="checkbox"/>	<input type="checkbox"/>	
Nodes	<input type="checkbox"/>	<input type="checkbox"/>	Gait	<input type="checkbox"/>	<input type="checkbox"/>	
Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	Sexual Maturity Rating	<input type="checkbox"/>	<input type="checkbox"/>	

Describe findings:

Health Education/Anticipatory Guidance:
(CHECK ALL COMPLETED)

<input type="checkbox"/> Nutrition/Weight Control	<input type="checkbox"/> Oral Health Care
<input type="checkbox"/> Body Image	<input type="checkbox"/> Adequate Sleep
<input type="checkbox"/> Development	<input type="checkbox"/> Seat Belt
<input type="checkbox"/> Helmets	<input type="checkbox"/> Passive Smoke/Smoking
<input type="checkbox"/> Regular Physical Activity	<input type="checkbox"/> Abstinence/Sex Education
<input type="checkbox"/> Suicide/Depression	<input type="checkbox"/> Drugs/Alcohol
<input type="checkbox"/> Self Exam	<input type="checkbox"/> Injury Prevention/Safety
<input type="checkbox"/> STD/HIV/AIDS	<input type="checkbox"/> Peer Pressure
<input type="checkbox"/> School Issues	<input type="checkbox"/> Acne
<input type="checkbox"/> Fire Arm Safety	<input type="checkbox"/> Limit TV
<input type="checkbox"/> After School Supervision	

Other: _____

Assessment:

Diagnosis:

Treatment Plan:

REFERRALS:

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

NEXT VISIT: 15 YEARS OF AGE

Health Provider Signature: _____