

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

## ADOLESCENCE: 17 YEARS

DATE:

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

Recommend practitioner have individual consultation with adolescent

<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>	
<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

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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

☐ 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"/>	

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

<input type="checkbox"/> Nutrition/Weight Control	<input type="checkbox"/> Oral Health Care
<input type="checkbox"/> Tobacco Use	<input type="checkbox"/> Injury Prevention/Safety
<input type="checkbox"/> Sex Education/Birth Control	<input type="checkbox"/> Sleep Patterns
<input type="checkbox"/> Driving	<input type="checkbox"/> Seat Belts
<input type="checkbox"/> Self Exam	<input type="checkbox"/> Drugs/Alcohol
<input type="checkbox"/> STD Discussed	<input type="checkbox"/> HIV/AIDS Discussed
<input type="checkbox"/> Regular Physical Activity	<input type="checkbox"/> Suicide Depression
<input type="checkbox"/> Body Image	<input type="checkbox"/> Work

Other: \_\_\_\_\_

**Assessment:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Diagnosis:**

\_\_\_\_\_

**Treatment Plan:**

\_\_\_\_\_

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\_\_\_\_\_

**REFERRALS:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

**NEXT VISIT: 18 YEARS OF AGE**

Health Provider Signature: