

Neighborhood Health Providers

Interval Adolescent History and Complete Physical Exam

12 – 21 yrs old

Date:		Age:		Sex:		Allergies:		
Wt:		Ht:		BMI:		BP:		
HR:		RR:		Temp:				
H I S T O R Y	Historian:			Current Meds (incl. fluoride, OTC & herbal):				
	Recent Health Status / Concerns:			Immunization Hx (Incl. adverse reactions):				
	School / Work Hx:			TB Assessment (screen if positive for exposure):				
	Vision / Hearing / Dental:			Elimination / Sleep:				
	Menstrual / GYN / Pregnancy Hx:			Relationships / Behavior :				
S C R E E N I N G	Nutrition:			Exercise:				
	Sex Activity Assessment:							
	Drugs / ETOH: <input type="checkbox"/> Y <input type="checkbox"/> N			Smoking: <input type="checkbox"/> Y <input type="checkbox"/> N				
	Depression : <input type="checkbox"/> Y <input type="checkbox"/> N			Mental Health: <input type="checkbox"/> Y <input type="checkbox"/> N				
P H Y S I C A L	General							
	Skin							
	HEENT							
	Neck							
	Heart							
	Lungs							
	Breast							
	ABD							
	GU/Rectal/Pelvic							
	Spine/EXT							
	Neuro							
	Assessment:							
P L A N	Anticipatory guidance: <input type="checkbox"/> Proper nutrition and exercise <input type="checkbox"/> Discussed TSE if ♂/BSE if ♀ <input type="checkbox"/> HIV Awareness							
	<input type="checkbox"/> Sex / Safe dating / Preventative Actions <input type="checkbox"/> Substance / Alcohol Use <input type="checkbox"/> Tobacco Use / Smoking Cessation							
	Other, specify:							
	Immunizations:							
	<input type="checkbox"/> Hgb/Hct (annually) <input type="checkbox"/> PPD (recognition of risk factors) <input type="checkbox"/> UA (annually) <input type="checkbox"/> Recommend dental exam <input type="checkbox"/> Visual acuity (annually) <input type="checkbox"/> Hearing (annually) <input type="checkbox"/> Chlamydia/Gonorrhea Screening (if sexually active)							
Other (as indicated)								
RTC:		Signature/Title:			Print Name:			