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GENERAL PEDIATRIC CLINIC / TEENAGER VISIT

(See Page 2 for Teenager Visit additional exams)

Completion of this form is voluntary.

Patient Name			Date of Birth	Today's Date
Age	Sex	Height	Weight	BMI
T	BP	P		R

Chief Concerns	Past Medical History General Health / Illnesses
Family Constellation and Concerns Household Members Concerns: (Employment, Separation, Divorce, Family Relations)	Allergies Medications Hospitalizations Surgeries Injuries / Burns / Fractures Dental Care Immunizations

Family Medical History Asthma Cancer CVI / MI Before 60 years High Cholesterol / Triglycerides Depression / Psychiatric Illness Diabetes HTN Renal Sickle Cell Anemia Substance Abuse / Alcoholism Sudden Death (Age) Tuberculosis (TB)	Sexual History (If appropriate) Dating <input type="radio"/> Yes <input type="radio"/> No Sexually Active <input type="radio"/> Yes <input type="radio"/> No Age at First Intercourse _____ STDs Pregnancies _____ Ab _____ Children _____ Fathered a Child <input type="radio"/> Yes <input type="radio"/> No Contraceptive Use <input type="radio"/> Yes <input type="radio"/> No Methods _____
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School History School Failed a Grade Attitude Towards School Goals / Career Absences in Past Year Plan to Drop Out This Year	Menstrual History Menarche _____ LMP _____ Regular Periods <input type="radio"/> Yes <input type="radio"/> No Cycle Length _____ Flow D _____uration Tampons Pads Dysmenorrhea Meds
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Social Activities / Hobbies Job Sports / Exercise Diet High / Low Weight in Past Year Peer Relations Dating Sleep Pattern Substance Use (Own and Friends) Cigarettes Alcohol Drugs	Anticipatory Guidance Breast / Testicular Self Exam Decision Making Sexuality Issues Birth Control Parenting Future Plans Nutrition Coping Skills Mood Changes / Depression Stress / Relief Activities Safety Driving / Seat Belts / Bike Helmet Guns / Personal Security Sun Protection	
Immunization	Drug Co. and Lot. No.	Expiration Date

Note - Present (+) or Absent (-) as Appropriate
(Cross off parts not examined or not applicable)

Physical Exam	N	Abn	Physical Exam	N	Abn
Skin: Acne-Comedones / Pustular / Nodular			Genitourinary	Tanner Stage 1, 2, 3, 4, 5	
Head: Symmetry, Scalp, Hair			Hernia		
Eyes: EOM, Pupils, Cornea, Conjunctive			Penis		
Ears: Pinnae, Canals, Tympanic Membrane			Testes	tes	
Nose: Nares, Turbinates			Scrotum		
Throat: Pharynx, Tonsils			Pelvic		
Neck: Movements, Thyroid			Ext. Genitalia		
Nodes: Axillary, Cervical, Inguinal, Submandibular			Cervix		
Breast: Tanner Stage — 1, 2, 3, 4, 5			Adnexa		
Development Masses			Uterus		
Habits: Nail biting, tics, etc.				Lab / Saline / Gram Stain	
Neuromuscular: Equilibrium, Motor Strength, Sensory, Coordination, Cranial Nerves, DTRs, Babinski			Gynecomastia (m)		
Spine: Posture, Hip and Shoulder Levels			Extremities: (Gait, Range of Motion of Joints)		
Lungs:			Anus (Rectal)		
Heart: Rhythm, S1, S2 Murmur			Sexual Development		
Abdomen: Contour, LSK, Mass					

Assessment: (Synopsis, health promotion, description of abnormal findings.)

Plan: (Treatment, education/counseling, referral)

Laboratory	Immunizations
Urinalysis dT	Status
Hgb / Hct	TB Screen
STD panel	MMR Status
Pap smear	Hepatitis B
Rubella titer	
Cholesterol	
Other	

SIGNATURE — Provider _____ Date Signed _____