



11 - 20 Year Child Health Supervision (EPSDT) Visit

NAME: _____ DOB: _____ DOV: _____ AGE: _____ SEX: _____ MED REC#: _____

HT: _____ (____%) Temp: _____ Pulse: _____ Meds: _____
 WT: _____ (____%) Pulse Ox-Optional: _____
 HC: _____ (____%) Resp: _____
 Allergies: _____ NKDA
 Reaction: _____

HISTORY:
Parent Concerns:

Initial/Interval History:

FSH: FSH form reviewed (check other topics discussed):
 Parent Concerns Discussed? (**Required**) Yes
 Standardized Screen Used? (Optional) Yes No
 See instrument form: Vanderbilt ADHD
 Other _____
DB Concerns: (e.g., behavior/sleep/school) _____

SENSORY SCREENING:
Any parent concerns about vision or hearing? Yes No
Vision: (one between 11 and 18 yrs)
 Acuity (Allen cards, Snellen chart or HOTV test) done Yes No
Hearing: (Subjective by history; required if not completed at school)
 Passed Screen Right Left Bilaterally
 Failed Screen Right Left Bilaterally
 Referred for: Audiological evaluations

PHYSICAL EXAMINATION (check appropriate box):

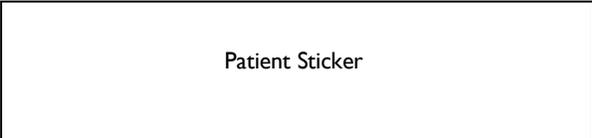
Clinician Observations/History: (HEADSS Suggested)		
Home		
After home school monitoring-who?	Y	N
Adequate family support system?	Y	N
Feel safe in neighborhood?	Y	N
Domestic Violence	Y	N
Education Grade:	School:	
Strengths (e.g., gifted, artistic, athletic, etc.)	Y	N
Feels connected to school? (e.g., favorite teacher)	Y	N
Any learning/attention struggles at school?	Y	N
Grade retention?	Y	N
Plans for future?	Y	N
Activities		
Extracurricular/religious activities	Y	N
Has best friend(s)	Y	N
Danger/Drugs		
Friends tried or using drugs or alcohol?	Y	N
Pt tried or using and substances or TOBACCO?	Y	N
Driving under the influence?	Y	N
Suicidality/Depression		
Trouble sleeping, irritability, withdrawal?	Y	N
Suicidal ideation?	Y	N
Family history of depression?	Y	N
Any concerns regarding body image?	Y	N
Sexuality		
Boyfriend or girlfriend?	Y	N
Has a parent or trusted adult to talk to?	Y	N
Sexually active?	Y	N
Birth control?	Y	N
Parent - Teen Interaction		
Interaction appears age appropriate	Y	N

	N L	AB	N E	COMMENTS NL-normal, AB-abnormal, NE-not examined
General				
Skin				
Fontanels				
Eyes: Red Reflex, Appearance				
Ears, TMs				
Nose				
Lips/Palate				
Teeth/Gums				
Tongue/Pharynx				
Neck/Nodes				
Chest/Breast				
Lungs				
Heart				
Abd/Umbilicus				
Genitalia/ Femoral Pulses				
Extremities, Clavicles, Hips				
Muscular				
Neuromotor				
Back/Sacral Dimple				

Clinician concerns regarding interaction:

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NAME: _____ DOB: _____
MED RECORD #: _____ DOV: _____



Patient Sticker

ANTICIPATORY GUIDANCE:

Select at least one topic in each category (as appropriate to family):

Injury/Serious Illness Prevention:

- Seat belts Drinking and driving Smoke alarms No smoking (Oklahoma Tobacco Helpline: 1.800.QUIT.NOW)
- Sun protection Bicycle helmet
- Other: _____

Violence Prevention:

- Adequate support system? Adequate supervision? Feel safe in neighborhood? Domestic Violence? Gun Safety
- Other: _____

Family Interaction/Communication:

- Family meetings Limit TV Adequate exercise
- Other: _____

Nutrition Counseling:

- Begin 2% cow's milk (~16 oz/day) Adequate fruits and vegetables
- Whole grains Healthy snacks Limit junk food Vitamins
- Other: _____

What to anticipate before next visit:

- Discipline Help teen have adequate balance of independence and supervision Define unacceptable behavior; provide clear rules (e.g., no curfew violations, how to earn privileges) Family meetings Other: _____

PROCEDURES:

- Hematocrit or Hemoglobin
- Urinalysis
- TB Test
- Cholesterol Screening
- STD Screening
- Pelvic Exam

DENTAL REMINDER

- Yearly dental referral Fluoride source?

IMMUNIZATIONS DUE at this visit:

- Tdap #** _____
 Given Not Given Up to Date

- MCV4 (meningococcal)**
 Given Not Given Up to Date

- HPV (papilloma)**
 Given Not Given Up to Date

- Flu (yearly)**
 Given Not Given Up to Date
 Date Flu previously given: _____

Catch-up vaccines:

- MMR #** _____
 Given Not Given Up to Date

- IPV #** _____
 Given Not Given Up to Date

- Varicella#** _____
 Given Not Given Up to Date

- HepA #** _____
 Given Not Given Up to Date

- HepB #** _____
 Given Not Given Up to Date

Vaccines for HIGH-RISK:

- PPV (pneumonia)**
 Given Not Given Up to Date

Reason Not Given if due: List Vaccine(s) not given:

- Vaccine not available _____
- Child ill _____
- Parent Declined _____
- Other _____

ASSESSMENT: Healthy, no problems

PLAN/RECOMMENDATIONS: Do vaccines/procedures marked above Other _____

See box above for Anticipatory Guidance Topics discussed at today's visit

Next Health Supervision (EPSDT) Visit Due: _____

Provider Signature: _____ **Date:** _____