**PHYSICAL EXAMINATION (check appropriate box):**

<table>
<thead>
<tr>
<th>N L</th>
<th>AB</th>
<th>NE</th>
<th>COMMENTS</th>
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<tbody>
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<td></td>
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<td>NL-normal, AB-abnormal, NE-not examined</td>
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<tbody>
<tr>
<td>General</td>
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<td>Skin</td>
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<td>Fontanel</td>
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<tr>
<td>Eyes: Red Reflex, Appearance</td>
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<tr>
<td>Ears, TMs</td>
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<td>Nose</td>
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<td>Lips/Palate</td>
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<td>Teeth/Gums</td>
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<td>Tongue/Pharynx</td>
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<td>Neck/Pharynx</td>
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<td>Chest/Breast</td>
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<td>Lungs</td>
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<td>Heart</td>
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<tr>
<td>Abd/Umbilicus</td>
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<td>Genitalia/ Femoral Pulses</td>
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<tr>
<td>Extremities, Clavicles, Hips</td>
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<td>Muscular</td>
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<td>Neuromotor</td>
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<tr>
<td>Back/Sacral Dimple</td>
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</tbody>
</table>

**SENSORY SCREENING:**

- Any parent concerns about vision or hearing? ☐ Yes ☐ No
- 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

**HISTORY:**

- Parent Concerns:
- Initial/Interval History:

**Clinician Observations/History: (HEADSS Suggested)**

- Home
- After home school monitoring-who? ☐ Yes ☐ No
- Adequate family support system? ☐ Yes ☐ No
- Feel safe in neighborhood? ☐ Yes ☐ No
- Domestic Violence ☐ Yes ☐ No
- Education Grade: School:
- Strengths (e.g., gifted, artistic, athletic, etc.) ☐ Yes ☐ No
- Feels connected to school? (e.g., favorite teacher) ☐ Yes ☐ No
- Any learning/attention struggles at school? ☐ Yes ☐ No
- Grade retention? ☐ Yes ☐ No
- Plans for future? ☐ Yes ☐ No
- Activities
- Extracurricular/religious activities ☐ Yes ☐ No
- Has best friend(s) ☐ Yes ☐ No
- Danger/Drugs
- Friends tried or using drugs or alcohol? ☐ Yes ☐ No
- Pt tried or using and substances or TOBACCO? ☐ Yes ☐ No
- Driving under the influence? ☐ Yes ☐ No
- Suicidality/Depression
- Trouble sleeping, irritability, withdrawal? ☐ Yes ☐ No
- Suicidal ideation? ☐ Yes ☐ No
- Family history of depression? ☐ Yes ☐ No
- Any concerns regarding body image? ☐ Yes ☐ No
- Sexuality
- Boyfriend or girlfriend? ☐ Yes ☐ No
- Has a parent or trusted adult to talk to? ☐ Yes ☐ No
- Sexually active? ☐ Yes ☐ No
- Birth control? ☐ Yes ☐ No
- Parent – Teen Interaction
- Interaction appears age appropriate ☐ Yes ☐ No

**Clinician concerns regarding interaction:**

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(EPSDT) 11 - 20 Year Visit Page 2

NAME: _______________________ DOB: __________
MED RECORD #: _____________________ DOV: ________

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 # __________
- MCV4 (meningococcal) Given [ ] Not Given [ ] Up to Date
- HPV (papilloma) Given [ ] Not Given [ ] Up to Date
- Flu (yearly) Given [ ] Not Given [ ] Up to Date

Catch-up vaccines:
- MMR # __________
- IPV # __________
- Varicella # __________
- HepA # __________
- HepB # __________
- 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: ______________________

OHCA Revised 03/14/2014