McLaren Medical Group

PEDIATRIC PHYSICAL EXAMINATION

AGE 11-12 Years

Date: _____ Age: _____ Accompanied By: _____

INTERVAL HISTORY / REVIEW OF SYSTEMS

See Pediatric/Adolescent History Form/Problem List/Med. List

Concerns/Additional History: _____

_____

_____

_____

_____

Nutrition: ☐ Diet for Age _____

_____

Elimination: ☐ WNL _____

_____

Sleep: ☐ WNL _____

_____

Behavior: ☐ WNL _____

_____

Hearing: _____

Vision: _____

DEVELOPMENT

☐ Reads for Pleasure
☐ Has Favorite Activities
☐ Shows Progress in School
☐ Communicates with Family Members

EDUCATION

Discussed and/or handout given:

☐ Nutrition
  ☐ Avoid Junk food
☐ Elimination
☐ Regular Exercise
☐ Sleep
☐ Regular Dental Visits
☐ Social/Family Interaction
☐ Behavior/Development
  ☐ Communication Skills
  ☐ Physical
☐ Injury Prevention
  ☐ Seat Belts
  ☐ Helmets/Bicycle Safety
  ☐ Substance Abuse
  ☐ General Injury Prevention
  ☐ Firearm Hazards
☐ Passive Smoke Exposure
☐ Sex Education
☐ Other: _____
_____
_____

PHYSICAL EXAMINATION

Weight _____ Height _____

See Growth Chart

T: _____ P: _____ R: _____ B/P: _____

KEY: ☑ WNL
☐ Not addressed or exceptions/abnormalities must be documented

☐ Gen. Appearance _____
☐ Head/Fontanel _____
☐ Eyes _____
☐ Ears _____
☐ Nose _____
☐ Mouth/Throat _____
☐ Lungs _____
☐ Heart _____
☐ Femoral Pulses _____
☐ Abdomen _____
☐ Genitalia _____
  ☐ Male/Testes Down _____
  ☐ Female _____
☐ Extremities _____
☐ Back _____
☐ Skin _____
☐ Neurologic _____
Comments: _____
_____

ASSESSMENT

☐ Well child
_____
_____
_____

PLANS/FOLLOW-UP

_____
_____
_____
☐ Next well child at age 13-14 years

IMMUNIZATIONS

Immunizations UTD?: ☐ Y ☐ N
☐ MCV4 (Meningoccal)
Varicella Vaccine Date: _____
Chickenpox Date: _____
HPV Series Completed: ☐ Y ☐ N
☐ Tdap
☐ MCIR Updated
☐ Physician provided face-to-face counseling with the parent/guardian at the time of administration of (list number) _____ vaccine(s) at this visit.

SCREENINGS

Vision Exam: R _____ L _____ Referral: ☐ Y ☐ N
Hearing Exam: R _____ L _____ Referral: ☐ Y ☐ N
Scoliosis Screen: Referral ☐ Y ☐ N
☐ Lead Screening Date: _____
☐ Lead Level Date: _____
PPD: ☐ Yes Date: _____ ☐ No

☐ Parent/guardian verbalized understanding of education/instructions
☐ See Progress Notes for additional documentation

Clinical Staff Signature: _____

Provider Signature: _____

Patient Name:

Date of Birth: