McLaren Medical Group
PEDIATRIC PHYSICAL EXAMINATION
AGE 15-18 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 _____

DEVELOPMENT

☐ Social/Family Interaction
☐ School Progress
☐ Sexual Activity
☐ Hobbies
☐ Alcohol/Tobacco Use

EDUCATION

Discussed and/or handout given:

☐ Nutrition
- ☐ Avoid Junk Food

☐ Elimination
☐ Regular Exercise
☐ Sleep
☐ Regular Dental Visits
☐ Behavior/Development
- ☐ Social Interaction
- ☐ Communication Skills
- ☐ Physical
- ☐ Sex Education

☐ Injury Prevention
- ☐ Seat Belts
- ☐ Wear Helmets
- ☐ Bicycle/Car Safety
- ☐ Substance Abuse
- ☐ Firearm Hazards

☐ Passive Smoke Exposure
☐ BSE/TSE Instruction
☐ 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 Adolescent

PLANS/FOLLOW-UP

☐ Visit in One Year

IMMUNIZATIONS

Immunizations UTD?: ☐ Y ☐ N
☐ MCV4 (Meningoccal)
☐ 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
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:

WELL CHILD EXAM - Adolescence: 15 - 20 Years

DATE	PATIENT NAME	DOB

Developmental Questions and Observations

You may use the following screening list, or an age appropriate standardized developmental instrument or screening tool.

Ask the patient to respond to the following statements:

Yes	No	
☐	☐	**Please tell me any questions or concerns you have today:**
		_____
☐	☐	**I eat breakfast everyday.**
☐	☐	**I am happy with how I am doing in school and/or at work.**
☐	☐	**I have one or more close friends.**
☐	☐	**I feel rested when I wake up.**
☐	☐	**I participate in at least one activity and/or interest other than school and work.**
☐	☐	**I do things with my family.**
☐	☐	**I feel good about my friends and school.**
☐	☐	**I know what to do when I feel angry, stressed or frustrated.**
☐	☐	**I have someone I can talk to.**
☐	☐	**I have questions about sexuality.**
☐	☐	**I get some physical activity every day.**
☐	☐	**I sometimes feel really down and depressed.**
☐	☐	**I sometimes feel very nervous.**

If the parent is present, ask the parent to respond to the following statements:

☐	☐	**I am proud of my child.**
☐	☐	**I talk to my child about alcohol, drugs, and smoking.**
☐	☐	**My child's school work matches his/her future goals.**
☐	☐	**My child's school work matches my future goals for him/her.**
☐	☐	**I talk to my child about sexuality and our family's values regarding sex.**
☐	☐	**I monitor my child's activities and social life.**

Please note: Formal developmental examinations are recommended when surveillance suggests a delay or abnormality, especially when the opportunity for continuing observation is not anticipated. (*Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*)

Additional Notes from pages 1 and 2:

Staff Signature: _____

Provider Signature: _____

Date: _____ **Time:** _____

Patient Name:

Date of Birth: