Clear Form

MINNESOTA Child and Teen Checkups

13 and 14-Year Well Visits

Patient information

Patient's name: _____

Medical record number: _____

Date of visit: _____ Date of birth: _____

Age: ____ years and ____ months Gender: _____

Accompanied by: _____

Health history

Parent, caregiver or patient concerns today:

◯ New patient: Comprehensive prenatal, health and family history reviewed

◯ Returning patient: Interim history reviewed

Pertinent personal health history, family history or changes:

Allergies: _____

Medications (including vitamins, supplements or OTC meds):

Social history

Patient lives with: _____

Primary caregiver(s): _____

Housing stability, food security or concerns:

Family changes or stressors, exposure to family or community violence:

Social and community supports:

Is the patient in foster care or out-of-home placement?

◯ No ◯ Yes (follow AAP guidelines: Primary Care Tools for foster care)

Daily activities

Nutrition (intake, type and quantity per day, concerns):

Physical activity (type and quantity per day):

Screen time, social media (type and quantity per day):

Sleep (patterns, bed time, hours of sleep per 24 hours):

Elimination (regularity, concerns):

Extracurricular activities:

Measurements

Weight: ____ kg (or ____ lbs. and ____ oz.), percentile for age: ____ %

Height: ____ cm (or ____ in), percentile for age: ____ %

BMI: ____ , percentile for age: ____ %

Blood pressure: ____ / ____ (rescreen if BP exceeds 120/80)

Vision screening (required at least once between 11-14 years)

Vision concern or risk ◯ No ◯ Yes: _____

Distance vision screening (Sloan 10-foot chart recommended)

Right eye: 10/ ____ Left eye: 10/ ____ ☐ Wearing corrective lenses

◯ Pass ◯ Refer ◯ Screening exception

Near vision screening (10-foot chart with 2.5+ lenses): ◯ Pass ◯ Refer

Vision screening notes:

Hearing screening (required at least once between 11-14 years)

Hearing concern or risk ◯ No ◯ Yes: _____

Pure tone audiometry:

	500 Hz, 25 dB	1000 Hz, 20 dB	2000 Hz, 20 dB	4000 Hz, 20 dB	6000 Hz, 20 dB
Right ear	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Left ear	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No

Result: ◯ Pass ◯ Rescreen ◯ Refer ◯ Screening exception

Hearing screening notes:

Developmental and social-emotional health

Surveillance (required)

(Refer to Bright Futures or SAHRC resources)

Patient, parent or caregiver concerns about patient's development, emotions or behavior?

◯ No ◯ Yes: _____

Peer relationships, school progress:

Observations of parent-teen interaction (strengths, concerns):

Mental health screening (required)

Instrument: ☐ PSC ☐ PHQ-9 ☐ PHQ-2 (if positive, do PHQ-9) ☐ BDI-2 ☐ KADS ☐ CDI-2 ☐ GAIN-SS

Result: ◯ Pass ◯ Concerns ◯ Refer

Other screening (optional): _____

Screening comments: _____

Risk assessment

Always wears seat belt ◯ Yes ◯ No: _____

Tuberculosis risk (may use MDH form) ◯ No ◯ Yes: _____

Tobacco or e-cigarette use or exposure ◯ No ◯ Yes: _____

Dyslipidemia risk (assess risk at least once between 12-16 years)

◯ No ◯ Yes: _____

Fluoridated water ◯ Yes ◯ No (consider supplement)

Menses (menarche, LMP, regularity, concerns): _____

STI risk assessment done?

◯ No ◯ Yes (if patient reports sexual exposure, assess for possible abuse or exploitation; document separately if needed)

Substance use risk assessment done and acted upon?

◯ No ◯ Yes (May use S2BI, CRAFFT or other method; document separately if needed)

patient label

PATIENT NAME: _____

MEDICAL RECORD NUMBER: _____

Review of systems

Constitutional	◯ Neg	◯ Pos		Neuromuscular	◯ Neg	◯ Pos	
HEENT	◯ Neg	◯ Pos		Skin	◯ Neg	◯ Pos	
Cardiovascular	◯ Neg	◯ Pos		Hematologic/lymph	◯ Neg	◯ Pos	
Respiratory	◯ Neg	◯ Pos		Endocrine/immune/allergic	◯ Neg	◯ Pos	
GI/GU	◯ Neg	◯ Pos		Psychosocial/behavioral	◯ Neg	◯ Pos	

Physical exam

◯ Normal ◯ Abnormal **General appearance** _____

◯ Normal ◯ Abnormal **Skin:** birthmarks, rash, lesions, scars _____

◯ Normal ◯ Abnormal **Nodes:** cervical, axillary, inguinal, other _____

◯ Normal ◯ Abnormal **Head:** shape and size, scalp, hair _____

◯ Normal ◯ Abnormal **Eyes:** lids, sclera, PERRLA, RR++, EOMs intact, corneal light reflex, cover test _____

◯ Normal ◯ Abnormal **Ears:** position, pinna, canals, TMs _____

◯ Normal ◯ Abnormal **Nose:** nare symmetry, patency _____

◯ Normal ◯ Abnormal **Mouth:** lift the lip: teeth, tongue, gums, mucosa, palate, throat, tonsils _____

◯ Normal ◯ Abnormal **Neck:** supple, ROM _____

◯ Normal ◯ Abnormal **Chest:** shape, symmetry, lung sounds, respiratory rate, Tanner stage _____

◯ Normal ◯ Abnormal **CV:** rate, rhythm, S1/S2, murmur, femoral pulses _____

◯ Normal ◯ Abnormal **Abd:** contour, umbilicus, liver, spleen, masses, bowel sounds, anus _____

◯ Normal ◯ Abnormal **GU:** labial-vaginal mucosa or penis, testes ↓ ↓, hernia, Tanner stage _____

◯ Normal ◯ Abnormal **MS:** ROM, limbs, strength, symmetry, gait, spine _____

◯ Normal ◯ Abnormal **Neuro:** tone, posture, DTRs, sensory, coordination _____

Assessment

☐ Well adolescent or C&TC visit completed ☐ Refer to separate documentation notes

☐ Additional findings or diagnoses (specify):

patient label

PATIENT NAME: _____

MEDICAL RECORD NUMBER: _____

Plan

Immunization review (required)

☐ Up to date (no vaccines due today) ☐ High risk: refer to schedule

Due for: ☐ HPV ☐ Influenza ☐ Other: _____

Given: ☐ HPV ☐ Influenza ☐ Other: _____

Reason not given, if due: _____

Fluoride varnish application (FVA) (optional)

☐ Benefits and risks discussed, verbal consent obtained

☐ FVA applied

Dental referral (required)

☐ Verbal referral for preventative dental care

Laboratory tests (if needed or due)

☐ Hemoglobin (required at least once for menstruating adolescents)

☐ TB blood test ☐ TB skin test; date to check: _____

☐ Other: _____

Anticipatory guidance (potential resources are hyperlinked)

Topics discussed, based on patient and family needs:

☐ Patient or family concerns addressed: _____

☐ Early adolescent development: growth; maturing body, feelings and thinking; peer and family relationships; identity and values

☐ Positive parenting: family mealtimes and activities; increasing independence and responsibility, regular and open conversations

☐ Healthy sexual development and sexuality: body changes, gender identity, attraction, values, goal-setting, safety, STI and pregnancy prevention

☐ Safe relationships (www.loveisrespect.org)

☐ Mental health: dealing with stress, healthy coping, talk with trusted adult; resources (school-linked mental health, Fast-Tracker, other)

☐ Balance sleep, physical activity, school, screen time (Family media plan)

☐ Nutrition and physical activity counseling provided, with a focus on:

☐ Oral health: brush 2 times and floss daily, see dentist every 6 months

☐ Safety in daily activities: sun, water, sports, vehicles, guns, internet use

☐ Risks of tobacco, alcohol, drug use; brief intervention or referral for use (may refer to SBIRT clinical tools, pocket card)

☐ Avoid any smoke exposure

☐ Smoke alarms on every level of home, carbon monoxide detectors in sleep areas of home

☐ Poison control information given: 1-800-222-1222

☐ Firearm safety and resources

☐ Taking charge of their own health: patient will get 1-on-1 time with clinician at next visit to talk about their own health goals and needs

☐ Other anticipatory guidance: _____

Referrals

HIPAA Compliant Referral Condition Code (**required** for complete C&TC)

◯ Patient needs further evaluation or follow-up (write in referred-to provider and reason for referral for ST, S2, *or* AV)

◯ **ST:** Referral to follow-up here or to another provider for newly identified condition:

_____

◯ **S2:** Continue follow-up with provider for previously referred condition:

_____

◯ **AV:** Parent or guardian declines referral for:

_____

◯ **NU:** No condition requires follow-up or referral

Additional recommendations

☐ Medications, supplements, treatments:

☐ Help for housing, food access (SNAP or other resources) or other concerns:

☐ Next well visit in one year, or sooner if needed: _____

☐ Quitting tobacco encouragement, resource provided

☐ Other community referrals, resources, education:

☐ Other recommendations (follow-up, actions to take at home, etc.):

PROVIDER SIGNATURE, CREDENTIALS			DATE
CLINIC NAME			
STREET ADDRESS	CITY	STATE	ZIP CODE