NAME:	MEDICAID ID:
DOB:	PRIMARY CARE GIVER:
GENDER:	PHONE:
DATE OF SERVICE:	INFORMANT:

Texas Health Steps

16 YEAR VISIT — CHILD HEALTH RECORD

HISTORY

☐ See new patient history form

INTERVAL HISTORY:
☐ NKDA Allergies:

Sexually Active: Y ☐ N ☐

Last Menstrual Period: _____
Menstrual Cycle # Days: _____

Current Medications:
If sexually active using contraception: Y ☐ N ☐

Visits to other health-care providers, facilities:

Parental concerns/changes/stressors in family or home:

Psychosocial/Behavioral Health Issues: Y ☐ N ☐
Findings:

☐ TB questionnaire*, risk identified: Y ☐ N ☐
**TB skin test if indicated* ☐ PPD placed
(See back for form)

NUTRITION*:
Problems: Y ☐ N ☐
Assessment:

**See Bright Futures Nutrition Book if needed*

IMMUNIZATIONS

☐ Up-to-date
☐ Deferred - Reason:

Given today: ☐ HAV ☐ HBV ☐ HPV ☐ IPV
☐ TD/TdaP ☐ Meningococcal ☐ MMR
☐ Pneumococcal ☐ Varicella ☐ Influenza

LABORATORY

☐ Up-to-date
☐ Deferred - Reason:

Ordered today:
☐ Hgb/HCT Results: _____
☐ Other:

UNCLOTHED PHYSICAL EXAM

☐ See growth graph

Weight: _____ (_____%) Height: _____ (_____%)
BMI: _____ (_____%) Heart Rate: _____
Blood Pressure: _____/_____ Respiratory Rate: _____
Temperature: _____

☐ Normal (Mark here if all items are WNL)

Abnormal (Mark all that apply and describe):

☐ Appearance	☐ Nose	☐ Lungs
☐ Head	☐ Mouth/throat	☐ GI/abdomen
☐ Skin	☐ Teeth	☐ Extremities
☐ Eyes	☐ Neurological	☐ Back
☐ Ears	☐ Heart	☐ Musculoskeletal

Abnormal findings:

Additional:
Breasts _____/5 Genitalia _____/5

Subjective Hearing Screening: P ☐ F ☐
Subjective Vision Screening: P ☐ F ☐

HEALTH EDUCATION/ANTICIPATORY GUIDANCE *(See back for useful topics)*

☐ Selected health topics addressed in any of the following areas*:
- Physical Growth and Development
- Nutrition
- Social and Academic Competence
- Safety

ASSESSMENT

PLAN/REFERRALS

Dental Referral: Y ☐
Other Referral(s)

Return to office:

Signature/title

Signature/title

Texas Health Steps

CHILD HEALTH RECORD

16 YEAR VISIT

Name: | Medicaid ID:

Typical Developmentally Appropriate Health Education Topics

15, 16 and 17 Year Old Visit

- Provide nutritious meals and snacks; limit sweets/sodas/high-fat foods
- Discuss family expectations concerning dating/sexual contact/abstinence/substance use/peer pressure
- Encourage physical activity for 1 hour/day
- Establish consistent limits/rules and consistent consequences
- Increase difficulty of chores to develop sense of family responsibility/self accomplishment
- Limit TV/computer time to 2 hours/day
- Pregnancy/STI prevention
- Promote healthy weight
- Self-breast/testicular exam
- Discuss self-safety in stalking/abusive relationship/bullying
- Do not ride in a car if use of alcohol/drugs involved
- During sports wear protective gear at all times
- Get to know teen's friends and their parents
- Lock up guns, enroll in gun safety class if interested
- Promote use of seat belt
- Provide information about sexuality/risks involved in sexual activity
- Teach self-safety at friend's home/car and how to exit situation
- Discuss additional help with teacher if there are concerns/bullying
- Discuss nonviolent conflict resolution, demonstrate anger management at home
- Discuss school activities and school work
- Encourage independent decision-making skills/thinking through steps of a project/encourage involvement in family decisions
- Establish an agreed-on curfew, after-school activities
- Establish self-responsibility for homework completion
- Observe for signs of depression/anxiety or other mental health issues
- Provide space/time for homework/personal time

**See Bright Futures for assistance*

TB QUESTIONNAIRE **Place a mark in the appropriate box:**	Yes	Do not know	No
Has your child been tested for TB? If yes, specify date	☐	☐	☐
Has your child ever had a positive TB skin test? If yes, specify date	☐	☐	☐
TB can cause fever of long duration, unexplained weight loss, a bad cough (lasting over two weeks), or coughing up blood. As far as you know:			
has your child been around anyone with any of these symptoms or problems? or	☐	☐	☐
has your child had any of these symptoms or problems? or	☐	☐	☐
has your child been around anyone sick with TB?	☐	☐	☐
Was your child born in Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe, or Asia?	☐	☐	☐
Has your child traveled in the past year to Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe, or Asia for longer than 3 weeks? If so, specify which country/countries?	☐	☐	☐
To your knowledge, has your child spent time (longer than 3 weeks) with anyone who is/has been an intravenous (IV) drug user, HIV-infected, in jail or prison, or has recently come to the United States from another country?	☐	☐	☐