

Patient intake 11-14 YEAR OLD HEALTH SUPERVISION

Please either circle or fill in responses

Patient Name: _____ Date of Birth: _____ Allergies: _____

Source of information for this visit: Mother Father Other: _____

Chief complaint/Appointment goal: _____

Is this visit related to an injury? YES NO

Patient (Caregiver) Preferences and Learning Needs Assessment (update annually):

- Preferred name of patient: _____
- Preferred spoken language: _____
- Preferred written language: _____

Preferred mode of communication:

Verbal Sign language Written Assistive Communication Device

Preferred method of learning:

Demonstration Printed materials Verbal explanation Video Internet/Patient Portal

Preferred method of communication:

No preference Printed letter Phone call Patient portal

Any Cultural or Religious beliefs that may affect care? None.

If Yes – please explain _____

How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?

Never Rarely Sometimes Often Always;

Barriers to learning? None. If yes, please explain: _____

Do you suspect your child is in pain? ◆ Staff- Evaluate pain with DVPRS or Numeric Scale*	YES	NO
Has the patient been seen elsewhere since their last clinic visit with us?	YES	NO
If yes, explain: _____ (◆ Staff- Request Records*)		

Review of Symptoms (Place an "X" in all categories that apply):

Hearing Concerns		Limb Pain		Ear Drainage	
Vision Concerns		Syncope (Fainting)		Sore Throat	
Snoring		Fever		Cough	
Chest Pain or Pressure		Headache		Wheezing	
Difficulty Breathing		Sinus Congestion Present		Vomiting	
Constipation/Change in Bowels		Nasal Discharge		Diarrhea	
Change in Urinary Habits		Ear Pain		Abdominal Pain	
Excessive Thirst		Pulling on Ears		Decreased Appetite	

Weight Loss / Gain _____ Sleep Disturbances _____ Other: _____

Biological Females: Have periods started? YES NO

If yes, when did patient's last menstrual period start: _____

Sexual Health History

Is your child sexually active? YES NO I'm not sure.

Family Screening

Are any members of the household currently <u>deployed or on extended duty</u> outside of the immediate area?	YES		NO
Is the caregiver in a situation where they are being verbally or physically hurt, threatened, or made to feel afraid?	YES		NO

Nutrition

Number of substantial breakfasts (# of days per week): _____

Number of Sweetened Drinks per day? _____

Amount of Fruit servings per day? _____

Amount of Vegetable servings per day? _____

Number of Meals with Family per week? _____

Oral Health

Has your child had a dental cleaning/ check-up in the past 6-12 months?

Yes. No.

Does your child brush using fluoride toothpaste?

Yes. No.

Do you have any concerns about your child's oral health?

Yes. No.

Access to Food

- Within the past 12 months I/we were worried whether our food would run out before we got money to buy more.
- Within the past 12 months the food I/we bought just didn't last and I/ we didn't have the money to get more.

Often True	Sometimes True	Never True
Often True	Sometimes True	Never True

Tuberculosis (TB) Screen

Has a family member or contact had active tuberculosis? Yes. No.

Has a family member had a positive tuberculin skin test? Yes. No.

Was your child born in a high-risk country? Yes. No.

Has your child traveled to a high risk country for more than one week? Yes. No.

Depression Screening (11 years and older)

Over the past 2 weeks, how often have you been bothered by any of the following problems?

- | | |
|--|--|
| 1) Feeling down, depressed, irritable, or hopeless? | 2) Little interest or pleasure in doing things? |
| <ul style="list-style-type: none">• Not at all• Several days• More than half the days• Nearly every day | <ul style="list-style-type: none">• Not at all• Several days• More than half the days• Nearly every day |

Exceptional Family Member Program (EFMP)

Is the patient enrolled in the EFMP program?	YES	NO
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Family history/Surgeries. Check all that apply.

Family History	Patient Surgeries
☐ Asthma ☐ Allergies ☐ SIDS ☐ Birth Defects ☐ Cancer ☐ Heart Attack (before the age of 50) ☐ High Blood Pressure ☐ High Cholesterol ☐ Kidney Disease ☐ Diabetes ☐ Vision Problems ☐ Hearing Problems ☐ Mental Health Concerns (ADHD, Anxiety, Bipolar, Depression, Intellectual Disability, Suicide, etc.) ☐ Alcohol/Substance Abuse ☐ Genetic/Metabolic Disease ☐ Other: _____	☐ NO History of Surgery ☐ Ear Tubes ☐ Tonsillectomy ☐ Adenoidectomy ☐ Circumcision ☐ Appendectomy ☐ Other: _____
◆ To be Completed by Corpsmen: **If parent/guardian placed a checkmark to any history item above, PLEASE document family member type that correlates to each in the space below.	

Home Environment

Who does the patient live with? _____

Household alcohol concerns?	YES	NO
Household members who Smoke	YES	NO
Vape?	YES	NO
Does the child attend School?	YES	NO
• Grade? • Name of School? • Activities child participates in?		

You are DONE! Please keep your paperwork with you and wait to be called back.

***** If you feel you received exemplary care from our staff today, PLEASE ask our front desk staff on the way out about our ICE and DAISY Recognition Programs! *****

(Below for Office Staff)

Weight: _____ kg

Height: _____ cm

Heart Rate: _____ bpm

BP: _____/_____

Respiratory Rate: _____ breaths/min

O2 sat (if Indicated): _____

Temperature: _____
(Temporal, oral, tympanic, axillary, rectal)

Vision: Corrective lenses? YES NO

Visual Acuity:

RIGHT EYE: 20/____, left (OS) 20/____, both (OU) _____

Important Notes from Corpsmen to Provider:

PARENT HANDOUT

11-14 Year Old Health Supervision

Your child's growth:

Weight: _____ lb. Percentile: _____

Height: _____ in. Percentile: _____

Create a MHS Genesis Patient Portal Account

1. Scan QR Code with camera
2. Go to website
3. Sign Self-Service Consent
4. Click "Need an Account"
5. Complete the registration process



Healthy Choices

- Serve healthy food and eat together as a family often.
- Encourage your child to get 1 hour of vigorous physical activity every day.
- Help your child limit screen time to 2 hours a day, not including homework time.

Click on me to go to the
"HealthyChildren.org" Website!
An American Academy of Pediatrics
(AAP) guide to your child's milestones,
growth and development. Search by age.



Feeling Happy

- Encourage your child think through problems themselves with your support.
- Help your child find healthy ways to deal with stress.
- Know your child's friends and their parents, where your child is, and what they are doing at all time.
- Show your child how to use talking to share feelings and handle disputes.

School and Friends

- Talk with your child as they take over responsibility for schoolwork.
- Help your child with organizing time if they need it.
- Help your child find activities they are really interested in, besides schoolwork.
- Talk to your child about relationships, sex, and values.

Safety

- Help your child find fun, safe things to do.
- Make sure your child knows how you feel about alcohol and drug use.
- If you have a gun, store in unloaded and locked with the ammunition locked separately.

Immunizations

- Gardasil-9 series (Human Papilloma Virus) - 2 doses separated by 6 months for ages 9-14
- Tdap #1 (Tetanus, Diphtheria and Pertussis) - ages 11-12
- Menveo #2 (Meningococcal meningitis) - ages 11-12
- Annual Influenza

Next health supervision appointment: Annually (Once every year!)

Patient specific guidance:
