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. Often True Sometimes True Never True
- 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

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?
- Not at all
- Several days
- More than half the days
- Nearly every day

2) Little interest or pleasure in doing things?
- 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

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?		

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

***** 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

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.

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.

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, Diptheria and Pertussis) - ages 11-12
- Menveo #2 (Meningococcal meningitis) - ages 11-12
- Annual Influenza

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

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Patient specific guidance:

_____

_____

_____

Pediatric Appointment Reminder

To expedite your visit, please visit this link:
https://bremerton.tricare.mil/Health-Services/Childrens-Health/Pediatrics

OR

Scan this QR code to fill out the intake paperwork required for your appointment. You can bring a printed copy or send it to us electronically via the Patient Portal.

Date: _____ Time: _____

Appointment for: _____

Location: Pediatric Clinic, Bldg 17, 3rd floor

Instructions:

- **Arrive to your appointment 10 min early**
- **Please call the PEDS Clinic with any questions or concerns: 360-475-4236**