Patient intake for 15+ 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):

Weight Loss		Excessive Thirst		Ear Drainage	
Weight Gain		Change in Urinary Habits		Sore Throat	
Sleep Disturbances		Fever		Cough	
Chest Pain or Pressure		Headache		Wheezing	
Difficulty Breathing		Sinus Congestion Present		Vomiting	
Syncope (Fainting)		Nasal Discharge		Diarrhea	
Snoring		Ear Pain		Abdominal Pain	
Change in Bowel Habits		Pulling on Ears		Decreased Appetite	

Limb Pain_____ 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 deployed or on extended duty 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

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

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.

Exceptional Family Member Program (EFMP)

Is the patient enrolled in the EFMP program?	YES	NO

Family history/Surgeries. Check all that apply.

Family History	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 programs for recognition! *****

(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

15+ Year 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.

Your Growing and Changing Teen

- Keep a variety of healthy foods at home.
- Encourage 1 hour vigorous physical activity a day.
- Help your teen visit the dentist at least annually.

Healthy Behavior Choices

- Talk with your teen about your values and your expectations on drinking, drug use, tobacco use, driving, and sex.
- Be there for your teen when they need support or help in making healthy decisions about their sexual behavior.

School and Friends

- Praise positive efforts and success in school and other activities.
- Help your teen find new activities they enjoy.
- Help your teen find and be a part of positive after-school activities and sports.
- Encourage healthy friendships and fun, safe things to do with friends.

Violence and Injury

- Do not tolerate drinking and driving.
- Insist that seat belts be used by everyone.
- Teach your teen how to deal with conflict without using violence.
- Make sure your teen understands that healthy dating relationships are built and respect and that saying "no" is OK.
- If you have a gun in your home, make sure it is unloaded and locked with ammunition locked in a separate place.

Immunizations

- Gardasil-9 series (Human Papilloma Virus) - if not yet received (3 doses at 0, 2, and 6 months for ages 15-26)
- Menveo #2 (Meningococcal meningitis) at 16 years of age
- Annual Influenza

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

Patient specific guidance:

_____

_____

_____