PARENT QUESTIONNAIRE

Instructions: Thank you for taking the time to complete this questionnaire about your daughter. This information will be used to provide her with the best possible care.

1) Please let us know how to reach you in case we need additional information:

Your name: _____ E-mail: _____

Phone #1: (____) _____ Phone #2: (____) _____

2) Please mark any conditions that run in your family (on the patient's mother's or father's side).

☐ High blood pressure ☐ High cholesterol ☐ Obesity ☐ Diabetes mellitus ☐ Heart disease ☐ Death of a parent or grandparent from heart attack before age 55 years ☐ Stroke ☐ Death of a parent or grandparent from stroke before age 55 years ☐ Peripheral vascular disease ☐ Cerebrovascular disease ☐ Asthma ☐ Allergies ☐ Cancer (breast, colon, ovarian, or uterine) ☐ Seizures ☐ Eating disorder ☐ Anxiety ☐ Depression ☐ Bipolar disorder or other mental health issues ☐ Excessive bleeding or clotting problems ☐ Other (infertility, polycystic ovary syndrome, endometriosis, uterine leiomyomas, or genetic diseases)

If other, please explain _____

3) Has your daughter ever had surgery or been hospitalized?

☐ Yes ☐ No Please describe: _____

4) Please list all prescription and over-the-counter medications your daughter is taking, including any vitamins or supplements:

_____

5) Do you have concerns about your daughter's health or lifestyle?

☐ Yes ☐ No Please describe: _____

Have you talked with her about your concerns? ☐ Yes ☐ No

6) Have there been any changes, health problems, or stresses in your family this past year?

☐ Yes ☐ No Please describe: _____

7) Have you noticed any changes in your daughter's behavior, such as unusual anger or irritability, withdrawal, secrecy, sadness, depression, or problems at home or school?

☐ Yes ☐ No Please describe: _____

8) Do you think that smoking, drinking, or drug use is a problem for your daughter or anyone in your family?

☐ Yes ☐ No Please describe: _____

9) Is your daughter exposed to violence, such as hitting or fighting, in your home or community?

☐ Yes ☐ No Please describe: _____

10) What are your daughter's strengths and talents? _____

11) Would you like help talking with your daughter about sex, drinking, drugs, smoking, or other social issues?

☐ Yes ☐ No Please describe: _____

12) Is there anything you would like to discuss with the doctor or nurse today?

☐ Yes ☐ No Please describe: _____

13) Can we share your answers to any of the questions above with your daughter?

☐ Yes ☐ No Please explain: _____

Primary Care Physician:

Name: _____ Telephone #: _____

Who referred you?

Name: _____ Telephone #: _____

List other doctors or mental health counselors your daughter has seen in the past year:

Name: _____ Telephone #: _____

Name: _____ Telephone #: _____

Ladies First OB/GYN LLC
Audry Castellanos-Vidaurre, M.D.
601 North Flamingo Road Suite 311
Pembroke Pines, FL 33028
954-435-3220
Fax 954-435-3667

CONSENT OF TREATMENT OF MINOR PATIENTS

I, _____ GIVE PERMISSION FOR
(PARENT OR LEGAL GUARDIAN)

_____ TO HAVE OB/GYN TREATMENT(S) BY
(PATIENT NAME)

DR. AUDRY CASTELLANOS-VIDAURRE. MY RELATIONSHIP TO THE

PATIENT IS _____.

_____
(SIGNATURE OF PARENT OR LEGAL GUARDIAN) (DATE)

_____
(SIGNATURE OF WITNESS) (DATE)

PATIENT REGISTRATION FORM

PATIENT INFORMATION: THIS SECTION REFERS TO THE PATIENT ONLY

Last Name: _____ First Name: _____ MI: _____ Social Security #: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Occupation: _____

Date of Birth: _____ **Sex:** M F **Marital Status:** Married Single Divorced Widowed **Preferred Language:** _____

Race: ☐ American Indian or Alaska native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Unknown/Declined to answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown/Declined to answer

Home phone: (_____)_____ cell phone: (_____)_____ work phone: (_____)_____

Best daytime number to reach you ☐ home ☐ work ☐ cell Is it ok to leave a message at any of the numbers? ☐ Yes ☐ No

If no, please designate which ones, if any: _____

Primary Care Physician's Name (if applicable): _____ How did you hear about us? _____

Spouse's Name: _____ Date of Birth: _____ Spouse's SS#: _____

RESPONSIBLE PARTY: THIS SECTION REFERS TO THE PERSON/PARTY WHO SHOULD RECEIVE THE BILL

Relationship to Patient ☐ Self (skip to next section) ☐ Parent ☐ Spouse ☐ Other (skip to next section) _____

Last Name: _____ First Name: _____ MI: _____

Social Security Number: _____ Birth date (mm/dd/yyyy): _____ Sex: ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

Home phone: (_____)_____ Cell phone: (_____)_____ Work phone: (_____)_____

INSURANCE INFORMATION

Primary Insurance Coverage: _____ Copay: $_____

Policy effective date: _____ Deductible: $_____ Met? ☐ Yes ☐ No If no, amount met: $ _____

Address: _____ City: _____ State: _____ Zip: _____

Policy Number: _____ Group Number: _____ Subscriber: _____

Subscriber's DOB: _____ Subscriber's SS #: _____

Secondary Insurance Coverage: _____

Address: _____ City: _____ State: _____ Zip: _____

Policy Number: _____ Group Number: _____ Subscriber: _____

Subscriber's DOB: _____ Subscriber's SS #: _____

☐ **Verified Patient Information** Staff Initials: _____

PATIENT NAME: _____ DATE OF BIRTH: _____

DISCLOSURE TO FAMILIES AND LOVED ONES (Emergency Contacts)

I authorize Ladies First OB/GYN, LLC, to disclose my health care information and to discuss my health care needs to those that I designate. I further authorize the release of my billing information and give these individuals the ability to pick up prescriptions and/or medications on my behalf. A photo ID is required for prescription pickup. These individuals will be considered my emergency contacts. Without authorization, no information may be shared. I authorize Ladies First OB/GYN< LLC to disclose my personal health information to the following people:

Name: _____ Relationship: _____ Phone: (____)_____

Name: _____ Relationship: _____ Phone: (____)_____

Name: _____ Relationship: _____ Phone: (____)_____

CONSENT TO TREATMENT FOR ALL PATIENTS

I hereby grant authorization and consent for medical treatment and/or procedures for myself or the patient for whom I am the parent or legally authorized representative for which I am signing for, and understand that no guarantee or assurance has been made as to the results for which may be obtained. I agree to allow my provider to access all of my medication history including medications prescribed by other providers.

_____
Patient initials

PHOTO DOCUMENTATION

I hereby grant authorization for the clerical staff to make a copy of my photo identification to be included in my confidential record as well as take a digital picture for additional protection against the theft of my medical identity. I further grant authorization for the clinical staff to take photo documentation of any injury or procedure that they feel is medically necessary to include in my confidential medical record.

_____
Patient initials

NOTICE OF PRIVACY PRACTICES

I received a copy of the Ladies First OB/GYN, LLC "Notice of Privacy Practices" today and agree with these privacy policies.

_____
Patient initials

INSURANCE ASSIGNMENT AND FINANCIAL RESPONSIBILITY

I hereby authorize the offices of Ladies First OB/GYN, LLC (LFOBGYN), to release any medical information required during the course of examination and treatment to my insurance company, and I permit payment to LFOBGYN from my insurance for any benefits due for their services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes but is not limited to coinsurance, copayment, deductible and non-covered services.

I understand that I am responsible for all charges incurred regardless of the insurance status. I agree to pay for services incurred after the patient has been charged for the office visit, such as labs, radiology, medical supplies, etc. I agree to pay my bill in full for services rendered by Ladies First OB/GYN, LLC providers.

_____
Patient initials

_____ _____

Date **Signature of Patient or Guardian if patient is Minor**

PATIENT NAME: _____ DATE OF BIRTH: _____

ALLERGIES

Do you have any allergies? YES or NO
If yes, list them;

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

PHARMACY

Name of pharmacy: _____

Address or crossroads: _____ City: _____

MEDICATION LIST

Please list any medications you are taking, including vitamins.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

PAST PREVENTITIVE HISTORY

First day of last period?	
Date of last pap smear?	
Date of last mammogram?	
Date of last colonoscopy?	
Date of last bone density/Dexa scan?	

PATIENT NAME: _____ DATE OF BIRTH: _____

PATIENT RESPONSIBILITY DISCLOSURE STATEMENT

BUSINESS HOURS

Our business and operating hours are: Monday – Thursday 8:00am-4:45pm & Friday 8:00am-11:45am.
Calls received after the hours noted above, unless it is an emergency, will be handled the next business day.

DEDUCTIBLES AND CO-PAYS

I understand that all charges for services rendered at Ladies First OB/GYN, LLC (LFOBGYN) are due and payable at the time of service, to include unmet deductible amounts, co-pays and co-insurance percentages for in-network or out-of network coverage.

BLOOD HANDELING FEE

I understand that there will be a fee of $20 for GYN patients and $40 for obstetrical (OB) patients, for labs drawn in the office. I have the option of going to the lab contracted with my insurance, to have blood drawn at no additional charge.

MEDICAL INSURANCE

We have contracts with many insurance companies, and we will bill them as a service to you. As a courtesy to our patients, we will verify your insurance benefits. The insurance benefits quoted to you does not guarantee payment from your insurance company, nor does it confirm active coverage at the time the claim is submitted. Payment of claims is subject to all terms, conditions, limitations, and exclusions of the insurance contract that you signed. As the responsible party, you are responsible for the charges if your insurance company declines to pay for any reason, as well as:

- Informing LFOBGYN of the current address and phone number for the patient and the responsible party.
- Presenting all current insurance cards prior to each office visit.
- Verifying at each visit that your patient information is current by speaking to the front receptionist and completing a new demographic form every year.
- Paying any additional amount owed within 30 days of receiving a statement from our office. When LFOBGYN receives an explanation of benefits (EOB) from your insurance company, any amounts that you need to pay will be billed to you.

AUTHORIZATION / REFERRAL POLICY

I understand that it is also my responsibility to obtain an authorization and/or referral through my primary care physician's office, if required by my insurance company. Failure to do so may result in charges being billed directly to me or my appointment being cancelled and rescheduled once I have obtained the appropriate authorization and/or referral.

RETURN CHECK POLICY

If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF) or Account Closed (AC), the patient or the Patient's Responsible Party will be responsible for the original check amount in addition to a $50.00 Service Charge. Once notice is received of the returned check, Ladies First OB/GYN, LLC will send out a letter and/or call to notify the Responsible Party of the returned check. If a response is not made within 15 days from the letter or call date by the Patient or the Responsible Party, the account may be turned over to our collection agency and a collection fee will be added to the outstanding balance – in addition to the $50.00 Check Service Charge.

_____
Pt Initials

NON-PAYMENT ON ACCOUNT

Accounts that are over 90 days past due may be placed with an outside collection agency for recovery. Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the Patient's Responsible Party, understands that Ladies First OB/GYN, LLC has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient, or the Patient's Responsible Party, understands that they are responsible for all costs of collection including, but not limited to, collection fees, all court costs and Attorney fees.

_____
Pt Initials

PATIENT NAME: _____ DATE OF BIRTH: _____

PRESCRIPTIONS AND/OR REFILLS

- If you do not have an appointment and are requesting a refill to be called to your pharmacy on allowable medications, please allow 48-72 hours to process your request. On all refills, please call your pharmacy and request your refill and your pharmacy will then notify us with the appropriate information needed to handle your request. We recommend calling a week in advance.
- New prescription requests, if possible, should be discussed during an office visit. Refill requests for 90 day mail in or Navy Hospital will be written and placed at the front desk for pick up, or if requested, mailed to you. Samples are only given out on the day of your appointment. No Exceptions
- Please note that we **DO NOT** refill prescriptions on the weekends or holidays. Weekends begin at 12:00 PM on Fridays and a holiday begins at 4:00 PM on the day prior to a National Holiday.

TEST RESULTS

- Allow 7- 10 business days after Labs and/or Tests were performed for our office to contact you with your results.

APPOINTMENTS

- Bring all medications you are currently taking to each appointment. We recommend you also keep a list of your current medications and a copy of your insurance company's medication formulary to bring to each appointment.
- If you are more than 15 minutes late for your appointment, we may have to reschedule you or ask you to wait for a period of time until the staff can find an opening in the schedule.
- Reminder; this is an OB/GYN office which means we also see and treat pregnant patients. In the event that the
- Physician has to leave the office to deliver a baby during your appointment time, there will be a delay.

PATIENT FORMS COMPLETION

- I acknowledge understanding there may be fees involved if I have a disability, financial, medication or similar forms that need to be completed by Ladies First OB/GYN, LLC office and/or physician. Ladies First OB/GYN, LLC require **14 business days** for processing and/or completion of any form. All form completion fees will be collected prior to form completion.

MEDICAL RECORDS COPY

- In compliance with Florida Statutes 395.3025, Rule 64B8-10.003 of the Florida Administrative Code, the following
- fees will be collected prior to the release of medical records from Ladies First OB/GYN, LLC:
- ***If requesting paper copies of your records:*** There will be a charge of $1.00 per page for the first 25 pages of written
- material and $.25 for each additional page

WIRELESS COMMUNICATION

- By providing a wireless or mobile telephone number, I permit Ladies First OB/GYN, LLC to use that number for contact. Contact includes receiving calls, texts, and messages, including pre-recorded messages and calls from an automatic telephone dialer (auto dialer), from Ladies First OB/GYN, LLC and their authorized agents.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THE ABOVE RELEASE OF MEDICAL INFORMATION, PAYMENT, AND OTHER OFFICE POLICIES. REFUSAL TO SIGN THIS STATEMENT RESULTS IN THE CANCELLATION OF APPOINTMENT AND TERMINATION OF FUTURE CARE.

PATIENT/GUARDIAN SIGNATURE	DATE
PRINT PATIENT/GUARDIAN'S NAME FROM ABOVE	GUARDIAN'S RELATIONSHIP TO PATIENT

CONFIDENTIAL FORM **DO NOT COPY** **NOT FOR RELEASE**

ACOG ADOLESCENT VISIT QUESTIONNAIRE

We strongly encourage you to discuss all issues of your life with your parent(s) or guardian(s). However, unless it is a life threatening issue, the information you give us on this form is CONFIDENTIAL between our doctors and nurses and you. It will not be released without your written consent. If you would like help filling out this form, please let the nurse know. IF YOU DO NOT FEEL COMFORTABLE ANSWERING A QUESTION, LEAVE IT BLANK AND YOUR DOCTOR OR NURSE WILL TALK WITH YOU ABOUT IT.

Name: _____ Age: _____ Today's Date: _____

Why did you come into our office today? _____

General Health: Please answer these general health questions. Ignore the last column. Your doctor or nurse will fill that out.

Friends and Family		**For doctor/nurse use**
Can you talk with your parent(s) or guardian(s) about personal things happening in your life?	☐ Yes ☐ No ☐ Sometimes	
Is there another adult you trust and can talk to if you have a problem?	☐ Yes ☐ No Who?	
Who do you live with? (Please circle all that apply.)	Mother Father Guardian Brother or Sister Other:	
Do you think your family has lots of fun together?	☐ Yes ☐ No ☐ Sometimes	
What do you do for fun?		
Do you think your parents care about you?	☐ Yes ☐ No ☐ Sometimes	
Do you have a best friend?	☐ Yes ☐ No	
School and Work		
Do you like school?	☐ Yes ☐ No ☐ Sometimes ☐ Not in school	
What grade are you in?	Grade: ☐ Not in school	
What school do you go to?	School: ☐ Not in school	
Do you do well in school?	☐ Yes ☐ No ☐ Sometimes ☐ Not in school	
How often have you skipped school?	☐ Never ☐ Once or twice ☐ A lot	
Do you have any learning problems?	☐ Yes ☐ No	
Do you have a job?	☐ Yes ☐ No If yes, doing what?	
Do you know what you want to be when you are older?	☐ Yes ☐ No If yes, what?	
Appearance and Fitness		
Do you have any concerns or questions about the shape or size of your body or the way you look?	☐ Yes ☐ No ☐ Not sure	
Do you want to gain or lose weight?	☐ Gain ☐ Lose ☐ Neither	
Have you ever tried to lose weight or control your weight by throwing up, using diet pills or laxatives, or not eating for a day?	☐ Yes ☐ No	
Have you ever had your body pierced (other than ears) or gotten a tattoo?	☐ Yes ☐ No ☐ Considering	
Do you exercise or participate in a sport at least five times per week that makes you sweat or breathe hard for 30 minutes?	☐ Yes ☐ No	
What sport, dance, or exercise programs do you participate in?		
How many fruits and vegetable portions do you eat each day?	☐ None ☐ 1–2 ☐ 3–4 ☐ 5–6 ☐ 7 or more ☐ Depends	
How many cups of milk, yogurt, ice cream do you eat each day?	☐ None ☐ 1–2 ☐ 3–4 ☐ 5–6 ☐ 7 or more ☐ Depends	

Safety/Weapons/Violence		**For doctor/nurse use**
Do you wear a seat belt when you ride in a car, truck, or van?	❑Yes ❑ No ❑ Sometimes	
Do you wear a helmet when you roller blade; skateboard; ride a bike, motorcycle, all-terrain vehicle, mini-bike, scooter; or go snowboarding or skiing? (Circle all activities in which you participate.)	❑Yes, for all of the activities circled ❑ No, for all of the activities circled ❑ Sometimes If sometimes, please explain:	
Do you or does anyone you live with have a gun, rifle, or other firearm?	❑Yes ❑ No ❑ Not sure	
Have you ever carried a gun or weapon?	❑Yes ❑ No	
Have you ever been in trouble with the law?	❑Yes ❑ No	
Has anyone touched you in a way that made you uncomfortable?	❑Yes ❑ No ❑ Not sure	
Has anyone ever forced you to have sex?	❑Yes ❑ No ❑ Not sure	
Has anyone ever hurt you physically or emotionally?	❑Yes ❑ No ❑ Not sure	
Relationships		
Are you going out with anyone?	❑Yes ❑ No	
Who do you find yourself attracted to sexually?	❑ Boys ❑ Girls ❑ Both	
Do you ever participate in sexual activities, such as touching or oral or anal sex? If yes, do you use anything to prevent disease?	❑Yes ❑ No ❑Yes ❑ No If yes, what do you use?	
Have you ever had sex with anyone? If yes, answer the questions in this section below. If no, do you plan to in the next year? When done answering this question, go to the section "Tobacco, Alcohol, and Drugs."	❑Yes ❑ No ❑Yes ❑ No ❑ Not sure	
How many sexual partners have you had in the past 3 months? How many total since you started to have sex?	Over past 3 months: Total:	
How old were you the first time you had sex (intercourse)?	Age:	
Have you ever had sex with a person of your same sex?	❑Yes ❑ No	
Do you use anything to prevent pregnancy?	❑Yes ❑ No ❑ Sometimes If yes, what do you use?	
How often do you and your partner(s) use a condom when you have sex?	❑ Always ❑ Sometimes ❑ Never	
Have you ever had sex for money or drugs?	❑Yes ❑ No	
Are you worried about your parents knowing that you are having sex?	❑Yes ❑ No	
Tobacco, Alcohol, and Drugs		
Have you or your close friends ever smoked cigarettes or cigars, used snuff, or chewed tobacco?	❑Yes, I have ❑ No, I have not ❑Yes, friends have ❑ No, friends have not ❑ Not sure about friends	
Have you or your close friends ever gotten drunk on wine, beer, or alcohol?	❑Yes, I have ❑ No, I have not ❑Yes, friends have ❑ No, friends have not ❑ Not sure about friends	
How much alcohol do you drink at one time?	❑ Do not drink ❑ 1–2 drinks ❑ 3 or more	
Do you ever have more than three drinks per occasion?	❑ Do not drink ❑Yes ❑ No	
In the last year, have you been in a car or other motor vehicle when the driver is drunk or has been drinking alcohol or using drugs? (This includes when you were the driver as well as other people.)	❑Yes ❑ No	
Would you call your parent(s) or guardian(s) for a ride if you needed to because the person who was supposed to drive you home had been drinking? (This includes when you were the driver as well as other people.)	❑Yes ❑ No ❑ Not sure	
Have you or your close friends ever used marijuana or other drugs (cocaine, heroin, meth, or ecstasy) or sniffed inhalants (glue, gasoline, or solvents)?	❑Yes, I have ❑ No, I have not ❑Yes, friends have ❑ No, friends have not ❑ Not sure	
Have you ever used a prescription drug to get high?	❑Yes ❑ No ❑ Not sure	

Have you ever used alcohol or drugs so much that you could not remember what happened (had a blackout)?	❑ Do not use drugs or alcohol ❑ Yes ❑ No	
Have you ever missed work or school because of using alcohol or drugs?	❑ Do not use drugs or alcohol ❑ Yes ❑ No	
Emotions		
Do you have more happy days or unhappy days?	❑ Happy ❑ Unhappy	
Have you ever seriously thought about hurting yourself?	❑ Yes ❑ No	
Do you get nervous or anxious more than other people do?	❑ Yes ❑ No	
During the past year, have you had any major good or bad changes in your life (death of someone close, loss of a pet, birth, graduation, moving, change of school, ending or starting a close friendship or romantic relationship)?	❑ Good ❑ Bad ❑ No changes ❑ Some good, some bad	
Tell me something good about yourself.		

What would you like to discuss with our nurses and doctors today?_____

Source: American Medical Association, Copyright 1998.

Date: _____ Name: _____ Patient Addressograph
LAST FIRST MIDDLE

Date of Birth: _____ Record Number: _____

Primary Physician: _____ Referral Source: _____

Contact information Patient phone: _____

May say, "Call physician"? ☐ Yes ☐ No May leave test results? ☐ Yes ☐ No

Parent name: _____

Parent phone: _____ Parent e-mail: _____

Insurance Carrier or Medicaid No: _____

ACOG ADOLESCENT VISIT RECORD

I. General Information

Current age: Current medications: Allergies:	Complaint(s), if any:

II. History

FOR PROBLEM VISIT ONLY—History of Present Illness (HPI) (please describe, if any):	FOR PROBLEM VISIT ONLY—HPI elements: (Location, severity, timing, modifying factors, quality, duration, context, associated signs and symptoms)

Menstrual History

	Response	Details/Notes		Response	Details/Notes
Age at menarche			Last Menstrual Period		
Length of periods			Normal or abnormal		
Cycle length			Cramping		
			Premenstrual symptoms		

Past Medical and Family History

Past Medical History	(+) Pos (0) Neg	Details/Remarks
Past and chronic illnesses (asthma, diabetes mellitus, hypertension, seizure disorder, migraines, arthritis, rheumatic fever, hepatitis, cancer, sickle cell anemia, pneumonia, tuberculosis or exposure to tuberculosis, blood clot, hyperlipidemia, scoliosis, other)		
Surgical procedures		
Physical trauma, injuries, or fractures		
Hospitalizations		
Transfusions of blood products		
Previous cervical cytology Date:	Normal/Abnormal/____	
Past Family History		
High blood pressure		
Parent with cholesterol level above 240 mg/dL		
Obesity		
Diabetes		
Parent or grandparent death from heart attack or stroke at an age younger than 55 years, coronary artery disease, peripheral vascular disease, cerebrovascular disease		

A nurse or nursing assistant, depending on staff capabilities and facilities, can obtain information for all shaded areas of the record.

Past Medical and Family History *(continued)*

Allergies or asthma		
Cancer		
Seizures		
Eating disorder		
Depression, bipolar disorder, or anxiety disorder		
Blood clots		
Tobacco, alcohol, or drug addiction		

Past Reproductive Health History

If sexually active, contraception and sexually transmitted disease prevention method(s):	Details/Notes
Use of condoms:	
Frequency of method use:	
Number of current partners:	
Age of initial coitus:	
Participate in oral or anal sex:	
Number of past partners:	
History of sexual abuse or violence:	
Pregnancies: G _____ P _____ AB _____	
Sexually transmitted diseases, including pelvic inflammatory disease, herpes simplex virus, and human papillomavirus:	
Vaginitis:	

III. Review of Systems

	(+) Pos (0) Neg	Details/Remarks
Constitutional (weight loss or gain, fever, malaise, appetite and eating habits)		
Eyes		
Ears, nose, mouth or throat problems		
Cardiovascular		
Respiratory		
Gastrointestinal (nausea, vomiting, bowel movements)		
Genitourinary (urination problems, vaginal discharge)		
Musculoskeletal (muscle or joint pain, scoliosis)		
Integumentary (acne)		
Breast tenderness, mass		
Neurologic (headaches)		
Psychiatric (depression, anxiety, exposure to violence or abuse)		
Endocrine (hirsutism, acne, heat or cold intolerance)		
Hematologic or lymphatic (blood disorder, anemia)		
Allergic or immunologic		

A nurse or nursing assistant, depending on staff capabilities and facilities, can obtain information for all shaded areas of the record.

IV. Health Guidance and Counseling

Positive From Adolescent Visit Questionnaire:	Details/Notes	Positive From Parent Questionnaire	Details/Notes
Routine as appropriate:		*Routine as appropriate:*	
Tobacco		Emergency contraception	
Alcohol and other drugs		Sexually transmitted diseases, including human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS)	
Drinking and driving*		Sexual victimization risk reduction†	
Diet (calcium, weight management, folic acid)		Pregnancy counseling (options, prenatal care, school)	
Exercise		Violence	
Responsible sexual behavior (abstinence or contraception)		Conflict resolution	
Condoms (how to acquire, use, and talk with partner)		Seat belts or helmets	
Suicidal ideation		Others	
Others			

*Encourage adolescents and their parents to develop agreements for picking up adolescents who have consumed alcohol or other substances.
†Discuss roles of alcohol and other drugs in increasing risks and in having negative, unintended consequences.

V. Vital Signs

Weight	Height	Blood Pressure
BMI*	Temperature	Pulse
BMI for Age		

*Body mass index (BMI) is computed as weight (in kilograms) divided by height in meters squared. Using pounds and inches, multiply the division results by 703. To determine prepregnancy weight-for-height status, go to the BMI chart. (See related charts at end.)

VI. Physical Examination. Check "not performed" if not examined (required if history indicates and at least once at ages 12–14 years, 15–17 years, and 18–21 years)

Body Area or Organ System	Normal	Abnormal	Not Performed	Body Area or Organ System	Normal	Abnormal	Not Performed
Skin				Breasts Tanner stage:			
Eyes				Genitourinary			
Ears, nose, mouth, or throat (teeth and gums)				Vulva or external genitalia			
Neck (thyroid, masses)				Pubic hair Tanner stage:			
Cardiovascular (peripheral system or auscultation)				Urethral meatus			
Respiratory (effort, auscultation)				Urethra			

A nurse or nursing assistant, depending on staff capabilities and facilities, can complete all shaded areas of the record.

VI. Physical Examination, ***continued***

Body Area or Organ System	Normal	Abnormal	Not Performed	Body Area or Organ System	Normal	Abnormal	Not Performed
Abdomen (masses, tenderness, hernia, hepatosplenomegaly)				Kidney or bladder			
Musculoskeletal				Vagina			
Extremities				Cervix			
Hematologic, lymphatic, or immunologic (lymph nodes)				Uterus			
Neurologic				Adnexa			
Psychiatric				Anus or perineum			
				Gastrointestinal (digital rectal examination)			

Details on Physical Examination

_____

_____

VII. Testing Ordered and Performed

	Tests Date	Results
General	Cholesterol* Lipoprotein profile† Tuberculin‡	
Gynecologic	Cervical cytology§ Gonorrhea‖ Chlamydia‖ Syphilis¶ HIV¶	
Other		

*Adolescents with parental cholesterol level greater than 240 mg/dL should be screened for total blood cholesterol level (nonfasting) at least once. Adolescents with either unknown family history or multiple risk factors may be screened for total serum cholesterol level (nonfasting) at least once.

†Adolescents with a parent or grandparent with coronary artery disease, peripheral vascular disease, cerebrovascular disease, or sudden cardiac death at an age younger than 55 years should be screened with a fasting lipoprotein profile.

‡Adolescents should receive purified protein derivative testing if they have been exposed to active tuberculosis; have lived in a homeless shelter, been incarcerated, or lived in another long-term care facility; have lived in an endemic area; are currently working in a health care setting; are HIV positive; are medically underserved or low income; have a history of substance abuse, including alcoholism; or have medical risk factors known to increase risk of disease if infected with *Mycobacterium tuberculosis*.

§Cervical cytology should be obtained approximately 3 years after first intercourse or no later than age 21 years.

‖Routine screening for HIV, chlamydial, and gonorrheal infection should be performed for all sexually active adolescents.

¶Serologic testing for syphilis should be conducted on sexually active adolescents who have a history of prior sexually transmitted diseases, multiple sexual partners, exchanged sex for drugs or money, used illicit drugs, been admitted to jail or other detention facility, or lived in an endemic area.

VIII. Assessment and Plan

Assessment	Plan

FOR PROBLEM VISIT ONLY—If E/M Code selected based on time:

Time spent counseling:	Total time with patient:
Topics of counseling:	

A nurse or nursing assistant, depending on staff capabilities and facilities, can complete all shaded areas of the record.