West Virginia Department of Health and Human Resources
Early and Periodic, Screening, Diagnosis and Treatment (EPSDT)
HealthCheck Program Preventive Health Screen

15, 16 and 17 Year Form

Name_______________ DOB_________ Age_______ Sex: M F Wt______ Ht______ BP______ Temp______ Pulse________ Screen Date__________

Allergies: □ NKDA ______________________ Current Meds: □ None______________________

Accompanied by: □ Parent □ Grandparent □ Foster parent/organization □ Other ______________________

History: □ No change
Concerns and questions:

Follow up on previous concerns:

Recent injuries, illnesses or visits to other providers:

Social/Family History: ✓ *Check those that apply*
□ No change
□ Family situation change

Parents working outside home? □ Mother □ Father
Child care? □ No □ Yes ______________________
Other changes since last visit:

Current Health Indicators: ✓ *Check those that apply*
□ No change □ LMP____________ □ N/A
Changes since last visit:

□ **GROWTH PLOTTED ON GROWTH CHART**
□ **BMI CALCULATED AND PLOTTED ON BMI CHART**
□ Normal elimination □ Normal sleep patterns
Comments:

Nutrition: □ Normal eating habits
□ Vitamins:______________________
Comments:

□ Passive Smoking Risk: □ Yes □ No

✓ *Check those that apply*
Dyslipidemia Risk: □ Low risk □ High risk
See Periodicity Schedule for risk indicators

Tuberculosis Risk: □ Low risk □ High risk
See Periodicity Schedule for risk indicators

□ **Behavior/Mental Health Screen:** ✓ *Check those that apply*
Appropriate behavior: □ Yes □ No
Fun activities: ______________________
____
Friend(s): □ Yes □ No
Concern(s): □ Yes □ No
Feelings: □ Content
□ Sad □ Less than a week □ More than a week
□ Angry □ Less than a week □ More than a week
□ Down/depressed □ Less than a week □ More than a week
□ Thoughts/plans to harm □ Self □ Others □ Animals
□ Trouble at school □ Trouble with the law

Behavioral concerns/comments: □ Yes □ No

Risk indicators: ✓ *Check those that apply* □ None identified
□ Poor self image □ Lack of physical activity
□ Weight or height concerns______________________
□ Tobacco use: □ Cigarettes/# per day__________ □ Chew
□ Alcohol use__________ □ Other drug __________
□ Peer pressure to do things you don't want to do:
____
□ Pressure to have sex □ Inappropriate touching
□ Does not wear protective gear, including seat belts
□ Access to firearms □ Has a firearm
□ Witnessed violence □ Threatened with violence
□ Excessive television/video game use (>2 hrs. per day)
School: Grade____________
□ Attends school regularly
□ Special classes______________________
Likes most about school:______________________
____
Likes least about school: ______________________
____
Proud of:______________________
____
Participates in activities______________________
Plans after high school______________________

Family/Sexuality:
□ Gets along with other family members

If you could, how would you change your life?
____
home? ______________________
family?______________________

□ Sex education/questions
Sexually active? □ Yes □ No STIs______________ □ N/A
Method of contraception______________________ □ N/A

□ **Vision Acuity Screen** (Obj @ 15 yrs) R_______ L_______

□ **Hearing Screen** as indicated by risk screen: 20db@
R ear: ______500HZ ____1000HZ ____2000HZ ____4000HZ
L ear: ______500HZ ____1000HZ ____2000HZ ____4000HZ

Oral Health Screen
Date of last dental visit______________________
□ Current oral health problems:

Physical Examination: ✓ *= Normal limits*
□ General Appearance □ Skin
□ Neurological □ Reflexes
□ Head □ Neck
□ Eyes □ Ears
□ Nose □ Oral Cavity/Throat
□ Lungs □ Heart □ Pulses
□ Abdomen □ Genitalia
□ Back □ Extremities

Abnormal Findings and Comments:
Possible Signs of Abuse □ Yes □ No

Health Education/Anticipatory Guidance:
□ Discussed □ Handout(s) given
Healthy and safe habits: nutrition, sleep, oral/dental care, risk behaviors, sexuality, injury and violence prevention, mental health, social competence, responsibility, school achievement, family relationships and community interaction, health care transition from adolescence to adulthood in the medical home
Other:

Assessment: □ Well Child □ Other diagnosis
□ Risk indicators reviewed/screen complete

Plan/Referrals:
For treatment plans requiring authorization, please complete the Medical Necessity Form on the reverse.

Immunizations: □ **UTD** □ Given, see vaccine record
Labs:

Referrals*: □ Behavioral/Mental health □ Dentist □ Vision
□ Hearing □ CSHCN **1-800-642-9704**
**See Provider Manual for automatic referrals*
□ Other referral(s)

Follow Up/Next Visit: □ 16 years of age □ 17 years of age
□ 18 years of age □ Other

____
Please print Name of Facility or Clinician

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Signature of Clinician/Title

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