La Loma
13/14 Year Old Well Child Male **Date: _____**

Name:_____ DOB:_____ Age:_____

Medications:		
Is your adolescent on any medications?	YES ☐	NO ☐
If Yes, Please List:		
Allergies:		
Does your adolescent have any allergies to medications?If yes, please list:	YES ☐	NO ☐
Sensory:		
Vision:		
Does your adolescent appear to be able to see well?	YES ☐	NO ☐
Hearing/Speech:		
Does your adolescent have any hearing deficits?	YES ☐	NO ☐
Does your adolescent have any speech problems?	YES ☐	NO ☐
Development:		
Does your adolescent do well in school?	YES ☐	NO ☐
What kind of grades does your child usually get?		
Nutrition: Does our child overall eat well (eat a generally diverse balanced diet)?	YES ☐	NO ☐
Is your child on any supplements? E.g. Fluoride, Vitamins, or Iron	YES ☐	NO ☐

Do you have any concerns regarding your child? ☐ **NO** ☐ **YES (Explain Below)**

Signed_____ Printed Name_____

Relationship to Patient? _____ Date_____

La Loma Internal Medicine and Pediatrics

MALE ADOLESCENT COMPREHENSIVE REVIEW OF SYSTEMS

Instructions: Answer yes if the following problems are CURRENT, FREQUENT or BOTHERSOME for your child. Explain all yes answers at the end of the last page.

Name: _____ DOB: _____

GENERAL:

Have you had a recent UNEXPLAINED change of weight 10+ pounds?	YES ☐	NO ☐
Does your child have a fever?	YES ☐	NO ☐

EARS, EYES, NOSE, THROAT:

Do you have nasal congestion?	YES ☐	NO ☐
Do you have a frequent runny nose?	YES ☐	NO ☐
Do you have a sore throat?	YES ☐	NO ☐
Have you noticed a change in your vision other than needing new glasses?	YES ☐	NO ☐
Are you having any hearing problems?	YES ☐	NO ☐

PULMONARY/ LUNGS:

Are you unusually short of breath? (If yes, AT REST or WITH ACTIVITY)	YES ☐	NO ☐
Do you cough up sputum or mucus most days?	YES ☐	NO ☐
Do you cough up blood?	YES ☐	NO ☐
Have you had a cough for longer than two to three months?	YES ☐	NO ☐
Does your child cough with exercise?	YES ☐	NO ☐

CARDIOVASCULAR/HEART:

Do you get palpitations often?	YES ☐	NO ☐
Do you have trouble breathing while lying flat?	YES ☐	NO ☐
Do you awaken at night gasping for air?	YES ☐	NO ☐

GASTROINTESTINAL/STOMACH, INTESTINES, LIVER GALLBLADDER:

Do you have pain in your stomach or abdomen often?	YES ☐	NO ☐
Do you have frequent nausea?	YES ☐	NO ☐
Do you have frequent vomiting?	YES ☐	NO ☐
Do you vomit to lose weight?	YES ☐	NO ☐
Do you have frequent diarrhea?	YES ☐	NO ☐
Are you constipated?	YES ☐	NO ☐

GENITOURINARY/ GENITALS, KIDNEY, BLADDER, URINATION:

Do you have any burning or discomfort with urination?	YES ☐	NO ☐
Do you have any blood in the urine or is the urine dark? (Tea Color)	YES ☐	NO ☐
Do you urinate more frequently than normal?	YES ☐	NO ☐
Do you have sores / lesions on your genitals?	YES ☐	NO ☐

Name: _____ DOB: _____

HEMATOLOGIC (BLOOD)

Do you have problems with bleeding or a history of hemophilia? (Circle which one)	YES ☐	NO ☐
Have you recently been told you are anemic?	YES ☐	NO ☐

MUSCULOSKELETAL / SKIN

Do you have any joint pain when exercising?	YES ☐	NO ☐
Do your joints swell or get red? (Circle one or both)	YES ☐	NO ☐

NEUROPSYCHIATRIC (NERVES, BRAINS)

Have you ever suffered from depression?	YES ☐	NO ☐
Have you thought about hurting yourself?	YES ☐	NO ☐

GU

Do you have any testicular masses?	YES ☐	NO ☐
Do you have any lesions on your penis?	YES ☐	NO ☐
Do you have any penile discharge?	YES ☐	NO ☐
Have you ever had a sexually transmitted disease?	YES ☐	NO ☐
Are you sexually active?	YES ☐	NO ☐

HEALTHCARE MTC:

Do you always wear a seatbelt at all times in a motor vehicle?	Yes ☐	No ☐
Do you wear sunscreen if you out in the sun for any length of time?	Yes ☐	No ☐
Do you smoke? (If yes, how packs a day? _____)	Yes ☐	No ☐
Do you drink alcohol at all? (If yes, how many in how long? _____)	Yes ☐	No ☐
Do you take any drugs?	Yes ☐	No ☐
Are there any violence issues in your life?	Yes ☐	No ☐

DO YOU HAVE ANY QUESTIONS OR CONCERNS?

Over the last 2 weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly Every day**
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐

🧸 Your Child's Checkup & What It Covers

Making the Most of Your Child's Annual Physical — With Clear Info About Billing

We want your child's yearly checkup to be helpful, healthy, and happy! Here's what's included—and what might come with extra costs—so there are no surprises.

🩺 What's Included in a Regular Checkup (Preventive Visit):

Your child's annual physical is all about keeping them growing strong! It includes:

- ✅ A full physical exam
- ✅ Tracking growth, development, and overall health
- ✅ Sports physical paperwork if needed
- ✅ Routine vaccines to keep your child protected
- ✅ Preventive lab orders (Lab benefit coverage is determined by your insurance company)

⚠️ What's *Not* Included — May Have Extra Charges:

Sometimes, other health concerns come up during the visit. If we treat or discuss things like:

- 🧠 Ongoing conditions (like ADHD, asthma, depression etc)
- 🤒 New symptoms (like a sore throat, rash, or injury etc)
- 💊 Medication changes or refills for chronic issues
- 💉 Tests for illness (like strep tests, X-rays, or extra lab work)
- 🗣️ Longer discussions about complex concerns

These are considered *separate* services by insurance and may come with a co-pay, deductible or other charges.

📋 Why Things Are Different Now:

In the past, we could sometimes include extra care in the checkup without extra billing. But, in an effort to follow current billing and insurance requirements, we now have to bill separately for non-preventive care even if it happens during the same visit.

💙 Our Promise to You:

We follow these rules to make sure everything is billed correctly and fairly. Our goal is to care for your child in one visit whenever possible—so you don't have to come back again and again.

If you ever have questions about your child's visit or the bill, our team is here to help. We want you to feel confident and informed every step of the way!