La Loma
13/14 Year Old Well Child Female **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?	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
Has your adolescent started her period yet?	YES	NO

Do you have any concerns regarding your child? []NO [] YES (Explain Below)

Signed_____ Printed Name_____

Relationship to Patient? _____ Date_____

Reviewed with Above_____

La Loma Internal Medicine and Pediatrics

FEMALE 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.

GENERAL: **Date:** _____

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

PATIENT NAME: _____ DOB: _____

HEMATOLOGIC (BLOOD) **Patient Name: _____**

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

OB/GYN AND BREAST (WOMEN ONLY):

When was your last menstrual period?	Date:	
Are they regular? (Days between Cycles?)	YES	NO
Number of pregnancies and/or deliveries		
Do you have problems with heavy vaginal bleeding or excessive menstrual pain?	YES	NO
Do you have vaginal discharge that is abnormal?	YES	NO
Are you sexually active?	YES	NO
Do you take extra calcium?	YES	NO
Do you do regular self-breast examinations?	YES	NO
Do you use contraceptives? If yes, list the type of Contraceptive:	YES	NO
Do you have any sores on your genitals?	YES	NO
Have you had a sexually transmitted disease?	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?

----------REVIEWED AND DISCUSSED WITH PATIENT

PHYSICIAN SIGNATURE: _____ DATE: _____