

**ADOLESCENCE**

	13 YRS Optional	14 YRS	15 YRS Optional	16 YRS	17 YRS Optional	18 YRS	19 YRS Optional	20 YRS
<b>HISTORY</b>								
Initial/Interval	●	●	●	●	●	●	●	●
<b>MEASUREMENTS</b>								
Height and Weight	●	●	●	●	●	●	●	●
Head Circumference								
Blood Pressure	●	●	●	●	●	●	●	●
BMI	●	●	●	●	●	●	●	●
<b>SENSORY SCREENING</b>								
Vision	----- O ----->						S	S
Hearing	S	S	S	S	S	S	S	S
<b>DEVELOPMENTAL/ BEHAVIORAL ASSESSMENT</b>	●	●	●	●	●	●	●	●
<b>PHYSICAL EXAMINATION</b>	●	●	●	●	●	●	●	●
<b>PROCEDURES - GENERAL</b>								
Hereditary / Metabolic Screening								
Immunization	●	●	●	●	●	●	●	●
Hematocrit or Hemoglobin								
Menstruating Females	A	A	A	A	A	A	A	A
Urinalysis	A	A	A	A	A	A	A	A
<b>PROCEDURES-PATIENTS AT RISK</b>								
Lead Screening								
Tuberculin Test	A	A	A	A	A	A	A	A
Cholesterol Screening	A	A	A	A	A	A	A	A
STD Screening	A	A	A	A	A	A	A	A
Pelvic Exam	A	A	A	A	A	A	A	A
<b>ANTICIPATORY GUIDANCE</b>								
Injury Prevention	●	●	●	●	●	●	●	●
Violence Prevention	●	●	●	●	●	●	●	●
Sleep Positioning Counseling								
Nutrition Counseling	●	●	●	●	●	●	●	●
<b>DENTAL REMINDER</b>	S	S	S	S	S	S	S	S