1-4 Years Visit

EPSDT Screening Date | | | / | | | / | | | | |

Medicaid ID# | | | | | | | | | | |

Name_____Birthdate_____Historian_____
Age_____Allergies_____Medications_____
Weight_____lbs. _____oz. Height _____in. HC _____ BMI_____ Temp. _____P_____ R_____ B/P* _____
(Required beginning at age 3)

Delivery Method: C-Section □ Vaginal □
Birth Weight _____
Gestation_____

Nutrition:
Breast milk □ Low-fat milk □
Fruits & vegetables
WIC: Yes□ No□

Elimination: Stools ___ Urine____
Sleep Patterns: Normal □ Abnormal □

Family History Changes in your family history?
No □ Yes □ _____
Patient Medical History:
Has the patient had any new problems or illnesses since the last visit? No □ Yes □
_____

Developmental Surveillance: Normal ☐ Abnormal ☐

Developmental Screening: Normal ☐ Abnormal ☐
(Required at 18 & 30 months using a standardized tool)
Autism Screening Completed: Yes□ No□
(Required at 18 & 24 months)

Sensory Screening:
Speaks well? Yes□ No□
Easy to understand? Yes□ No□
Hears well? Yes□ No□
Audiometric Hearing Screen (Required at age 4)

Right	Left
500 hz_____	500 hz _____
1000 hz_____	1000 hz _____
2000 hz_____	2000 hz_____
4000 hz_____	4000 hz_____

(Record decibel level)
Vision Reading (Required at ages 3 & 4)**:** L_____ R_____
Notices small objects? Yes□ No□

Lab:
Lead Risk Assessment: High_____ Low_____
*Blood Lead Test (Required at ages 1 & 2): _____
*Lipid Panel (Ages 2 & 4): _____
*Anemia Testing (Hgb/Hct required at age 1)
*Other:_____

Fluoride varnish applied (< age 3): Yes□ No□

Physical Exam (UNCLOTHED Yes □ No □**)** √ **= normal** **X = abnormal**

General	□
Head	□
Neck	□
Eyes	□
Alignment	□
Ears	□
Nose	□
Throat/Mouth/Teeth	□
Lungs	□
Heart	□
Abdomen	□
Femoral Pulses	□
Genitalia	
Female	□
Male	□
Testes	□
Spine	□
Extremities	□
Gait	□
Skin	□
Neuro	□

Anticipatory Guidance (Check all that apply)
Safety
□ Smoke detectors
□ No smoking in home
□ Car Seat/Booster seat (>40 lbs)
□ Firearm safety
□ Outdoor safety (supervision)
□ Water safety (swimming lessons)
□ Bike helmet
Health and Nutrition
□ Low fat milk from a cup
□ Encourage active play
□ Brush teeth
□ Encourage fruits and vegetables
□ Self feeding/finger foods
□ Supplements
Psychosocial/Behavioral Assessment
□ Potty training
□ Praise good behavior
□ Encourage independence
□ Developing routines
□ Friends and playmates
□ Daycare, pre-school
□ Discipline, time out
□ Family

Impression:
□ Normal growth & development
Other:_____
_____
_____

Immunizations:
Up to date: Yes□ No□
Immunization(s) given:
_____
_____
_____
Vaccine information given:
Yes□ No□
_____

Dental referral: Yes□ No□
_____
*Fluoride Supplementation Yes □ No □

Plan/Referrals:
_____
Next EPSDT visit _____

_____
MD/NP Signature

**Risk assessment to be performed with appropriate actions to follow, if positive; otherwise at the standard age according to AAP/Bright Futures*