

**1-4  
Years  
Visit**

EPSDT  
Screening  
Date

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Medicaid  
ID#

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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

Plus Lens L \_\_\_\_\_ R \_\_\_\_\_

**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

|   |                          |            |              |
|---|--------------------------|------------|--------------|
| <b>Physical Exam (UNCLOTHED)</b> Yes <input type="checkbox"/> No <input type="checkbox"/> |                          | √ = normal | X = abnormal |
| General   | <input type="checkbox"/> |            |              |
| Head  | <input type="checkbox"/> |            |              |
| Neck  | <input type="checkbox"/> |            |              |
| Eyes  | <input type="checkbox"/> |            |              |
| Alignment   | <input type="checkbox"/> |            |              |
| Ears  | <input type="checkbox"/> |            |              |
| Nose  | <input type="checkbox"/> |            |              |
| Throat/Mouth/Teeth  | <input type="checkbox"/> |            |              |
| Lungs   | <input type="checkbox"/> |            |              |
| Heart   | <input type="checkbox"/> |            |              |
| Abdomen   | <input type="checkbox"/> |            |              |
| Femoral Pulses  | <input type="checkbox"/> |            |              |
| Genitalia   |                          |            |              |
| Female  | <input type="checkbox"/> |            |              |
| Male  | <input type="checkbox"/> |            |              |
| Testes  | <input type="checkbox"/> |            |              |
| Spine   | <input type="checkbox"/> |            |              |
| Extremities   | <input type="checkbox"/> |            |              |
| Gait  | <input type="checkbox"/> |            |              |
| Skin  | <input type="checkbox"/> |            |              |
| Neuro   | <input type="checkbox"/> |            |              |

**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 CPT only copyright 2010 American Medical Association. All rights reserved.*