**11-21 Years Visit** EPSDT Screening Date | | | / | | | / | | | | | Medicaid ID# | | | | | | | | | |

Name_____Birthdate_____Historian_____
Age_____Allergies_____Medications_____
Weight_____lbs. _____oz. Height _____in. BMI _____ B/P _____ Temp. _____P_____ R_____

**History Update**
Changes in your family history? Yes□ No□
_____
Has the patient had any new problems or illnesses since the last visit? Yes□ No□
_____

**Problems/Concerns**
_____

**Nutrition**
Adequate diet ☐ Inadequate ☐
Supplements ☐ Physical Activity ☐

**Elimination**
□ Stool_____
□ Urine_____

**Sleep**
☐ Normal ☐ Abnormal

**Sensory Screening**
***Hearing** (Required once between ages 11-14, 15-17 & 18-21)
Audiometric Hearing Screen **Pass** □ **Failed** □

| Right | Left |
|---|---|
| 500 hz _____ | 500 hz _____ |
| 1000 hz _____ | 1000 hz _____ |
| 2000 hz_____ | 2000 hz _____ |
| 4000 hz _____ | 4000 hz _____ |
| 6000 hz _____ | 6000 hz _____ |
| 8000 hz _____ | 8000 hz _____ |

**(Record decibel level)**

***Vision** (Required at ages 12 & 15)
Reading: L_____ R_____

☐***Tobacco, Alcohol and drug assessment** Yes □ No □
☐ **Depression Screening** (begins at age 12) Yes □ No □
☐ **Developmental Surveillance**
Grade level _____
Any problems in school? Yes □ No □
Student progress:_____

**Lab**
☐*Anemia testing (Hgb/Hct )
☐*Lipid profile (Required once between ages 9-11&17-21)
☐*HIV (Required once between ages 15-18)
☐*STI (if sexually active) _____
☐*Cervical Dysplasia screening (required at age 21)
☐*TB Testing

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

| | |
|---|---|
| General | □ |
| Head | □ |
| Neck | □ |
| Eyes | □ |
| Ears | □ |
| Nose | □ |
| Throat/Mouth/Teeth | □ |
| Chest | □ |
| Breasts | □ |
| Lungs | □ |
| Heart | □ |
| Abdomen | □ |
| Femoral Pulses | □ |
| Genitalia/ | □ |
| Female | □ |
| Male | □ |
| Spine | □ |
| Extremities | □ |
| Skin | □ |
| Neuro | □ |

**Anticipatory Guidance/Safety**
□ Smoke detectors, no smoking in home
□ Seat belt
□ Bike helmet, street safety
□ Swimming, water safety
□ Firearm safety
□ STI counseling/screening
□ Reproductive health
□ Substance abuse
□ Tobacco Cessation

**Health/Nutrition**
□ Exercise/Weight
□ Healthy food choices
□ Supplements
□ Encourage sports, exercise
□ Acne
□ Brush teeth

**Psychosocial/Behavioral**
□ Conflict resolution
□ Limit TV, computer games
□ Bullying
□ Peer pressure
□ Coping Skills

**Impression**
Well Child/ Adolescent, normal growth and development
_____
_____

**Plan/Referrals**
_____

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

**Dental referral:** Yes □ No □
_____
*Fluoride Supplementation Yes □ No □
(**Assess fluoride supplementation needs through age 16)**

**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*

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