

**3-5  
Days  
Visit**

EPSDT  
Screening  
Date

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Medicaid  
ID#

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Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Historian \_\_\_\_\_  
 Age \_\_\_\_\_ Allergies \_\_\_\_\_ Medications \_\_\_\_\_  
 Weight \_\_\_\_\_ lbs. \_\_\_\_\_ oz. Length \_\_\_\_\_ in. Head circ. \_\_\_\_\_ cm Temp. \_\_\_\_\_ P \_\_\_\_\_ R \_\_\_\_\_ BP\* \_\_\_\_\_

**Nutrition**

- Breast
- Formula  
Brand \_\_\_\_\_  
With iron? Yes  No

WIC: Yes  No

**Delivery Method:**

- C-Section  Vaginal

**History:**

Are there any changes in your family history?

No  Yes  \_\_\_\_\_

Has the patient had any new problems or illnesses since birth?

No  Yes  \_\_\_\_\_

**Problems/Concerns**

- Spitting up Yes  No
- Constipation Yes  No
- Colic Yes  No
- Stuffy nose Yes  No
- Sleep Yes  No

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**New Born Blood Screening:**

Yes  No  Date: \_\_\_\_\_

**Hearing:**

Responds to sounds Yes  No

Newborn hearing screen:

Normal  Repeat  Not done

**Vision:**

Look at parent's face Yes  No

Follows with eyes Yes  No

**Developmental Surveillance:**

Normal  Abnormal

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

- General
- Head
- Fontanel
- Neck
- Eyes
- Red Reflex
- Ears
- Nose
- Throat
- Lungs
- Heart
- Abdomen
- Femoral Pulses
- Umbilical Cord
- Genitalia  
Female   
Male   
Testes   
Circumcision
- Spine
- Extremities
- Hips
- Skin

**Anticipatory Guidance**

- Car seat, facing backwards
- Smoke free environment
- Smoke detectors in home
- Hot water < 120 degrees
- No bottle propping
- Sleep on back
- Crib Safety

**Counseling for Nutrition/Diet**

- If bottle fed, 26-32oz/day
- If breast fed, nurses 8-10 times/day
- Delay solid foods
- Bowel movements
- Strong urinary stream, if male
- Fever

**Psychosocial/Behavioral Assessment**

- Temperament
- Sleeping habits
- Infant bonding
- Support for mother
- Day care plans

**Impression**

- Well baby normal growth

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**Plan/Referrals** \_\_\_\_\_

Immunizations up to date?

Yes \_\_\_\_\_ No \_\_\_\_\_

Vaccine Information provided?

Yes  No

Next EPSDT visit \_\_\_\_\_

\_\_\_\_\_  
MD/NP Signature