

**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. Weight for Length _____ (through 18 months) HC _____ (up to 24 months)
BMI _____ (beginning at 24 months) 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)
*TB Assessment _____
Other _____

Fluoride varnish applied (< age 5): Yes No

Physical Exam (UNCLOTHED) Yes <input type="checkbox"/> No <input type="checkbox"/> \checkmark = 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 Recommendations for Preventive Pediatric Health Care - Bright Futures/American Academy of Pediatrics.*