5-10 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

Any changes in your family history? Yes □ No □

____

Has the patient had any new problems or illnesses since the last visit?

No □ Yes □___________________________________

Problems/Parental Concerns

____

Nutrition

Low fat milk?	Yes □ No □
Variety of fruits/vegetables?	Yes □ No □
Eats breakfast?	Yes □ No □
Eats supper with family	Yes □ No □

***Hearing Screen** (Required at ages 5, 6, 8 & 10)

Audiometric Pass □ Fail □

Right	Left
500 hz________	500 hz________
1000 hz _______	1000 hz _______
2000 hz _______	2000 hz _______
4000 hz _______	4000 hz _______

(Record decibel level)

***Vision Screen** (Required at ages 5, 6, 8 & 10)

Reading: L ______ R_______

Developmental Surveillance

Grade level ________

Any problems in school? Yes □ No □

Student progress:________________

Labs:

Lead risk assessment: High____ Low____

*Blood lead test _______

*Anemia Testing (Hgb or Hct) __________

Lipid Panel (Ages 6&8, required once between ages 9-11)

____

*TB Test ______________________

*Other test______________________

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 use
- □ Stranger Danger
- □ Booster seat
- □ Bike helmet, street safety
- □ Water safety, swimming lessons
- □ Firearm safety
- □ Sunburn prevention

Health/Nutrition

- □ Low fat milk and snacks
- □ Encourage fruits and vegetables
- □ Encourage active play, sports
- □ Diet/Supplements
- □ Brush teeth

Psychosocial/Behavioral

- □ Bullying
- □ Peer Pressure
- □ Counseling for physical Activity
- □ Limit TV, computer games
- □ Give choices, encourage independence
- □ Set limits, provide consequences
- □ Puberty changes

Impression

□Well Child, normal growth and development

____

____

Plan/Referrals

____

____

Immunizations

Up to date: Yes □ No □

Immunization(s) given:

____

____

Vaccine information given: Yes □ No □

____

Next EPSDT visit: ______________

Dental Referral: Yes □ No □

____

*Fluoride Supplementation Yes □ No □

____

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.*