Preventive Care Forms

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Age-Specific Encounter Forms (pp. 2 - 19) Updated 2014 Body Mass Index (BMI) Calculator - Child & Teen (p. 20) Updated 2014

CDC Growth Charts (pp. 21 - 29) Updated 2014

Medical and Family History Form - English and Spanish (pp. 30 -31)

Objective Hearing and Vision Form (p. 32) Updated 2015

PED	IATRIC	VISIT 3 to 5 DAY	2		DATE OF SERVICE_				
NAME				M / F	DATE OF BIRTH	AGE			
		/% HEIGHT/							
Perina	[,] health hi tal history	story documented & updated?	<u>Brea</u>	ast/bottle					
Conce	ms		Nun	hber BM's	s in 24 hours?	, dry in 24 hours?			
Sleep:	nal Depre	CIAL ASSESSMENT: <u>Child care</u> : ession? Yes / No	<u>Edu</u>	<u>cation</u> : ⊦	lold to feed □ Use of p				
New m		es in family: (circle all that apply) separation, chronic illness, death, recent move, r	Soc	-	TORY GUIDANCE				
Enviro	onment: S	Smokers in home? Yes / No	Par	enting : F	Respond to cry 🗆 Trust	-building 🗆 Holding, comfort 🗆			
History		es, accidents? Yes / No	Play and communication: Crying is communication □ Voices, mobiles, music, pictures □						
<u>Risk /</u> PHYS	Assessn SICAL E	glect or abuse? Yes / No nent: TB Circle Positive/Negative (Annual) EXAMINATION	Sne	ezing, hi	per/skin care				
Wnl □		(describe abnormalities) Appearance/Interaction		••••	•	riding infant car seat □			
		Growth	-	-	v	scape plan □ Hot water set at 120° □			
		Skin/Umbilicus	Hot	liquids 🗆		ol # \Box Fall prevention (heights) \Box safe storage) \Box Water safety (tub) \Box			
		Head/Face/Fontanelles		i i leave u					
		Eyes/Red reflex/Cover test	PL.	ANS/OI	RDERS/REFERRA	LS			
		Ears Nose	1.	Immuniz	ations ordered 🗆				
		Mouth/Gums				een 🗆			
_	_		3.		ventive appointment				
		Neck/Nodes Lungs	4.	Referrals	s for identified problems	s? (specify)			
		Heart/Pulses Chest/Breasts							
		Abdomen Genitals/Circumcision	- 						
		Extremities/Hips/Feet Neuro/Reflexes/Tone							
		Vision (gross assessment) Hearing (gross assessment)	- <u> </u>						

Signatures:

PED	IATRIC	VISIT 0 to 1 MONTH	3			DA	TE OF SE	RVICE	
NAME			M	/ F	DATI	E OF BI	RTH	AGE	
		% HEIGHT/							
Family Perina	atal histor	istory documented & updated? y documented & updated?	<u>Breast/b</u>	<u>ottle</u> : adde	: Amou <u>er</u> : Nun	unt & fre		_, dry in 24 hours?	
<u>Sleep</u>	: nal Depre	CIAL ASSESSMENT: <u>Child care</u> : ession? Yes / No	<u>Educatio</u>	<u>on</u> : ⊢	lold to	feed 🗆	Use of pa		
Recent changes in family: (circle all that apply) New members, separation, chronic illness, death, recent move, loss of job, other					e out fo		DANCE: t Parent	al adjustment 🗆	
Envir	onment:	Smokers in home? Yes / No	<u>Parentir</u>	<u>ոց</u> ։ Բ	Respon	d to cry	□ Trust-b	ouilding 🗆 Holding, comfort 🗆	
Histor Evider Risk	nce of neg Assessr	es, accidents? Yes / No glect or abuse? Yes / No nent: TB Circle Positive/Negative (Annual)	Voices, I	mobi Diap	les, mu per/skir	usic, pic n care ⊑	tures □ I Bathing	communication □ & washing hair □	
				•	•		•	d hand smoke □	
Wnl □		(describe abnormalities) Appearance/Interaction	•	•					
		Growth	Injury prevention: Rear facing/rear riding infant car seat □ Sleep on back □ Smoke detector/escape plan □ Hot water set at 120 Choking/suffocation □ Poison control # □ Fall prevention (heights) □ Hot liquids □ Firearms (owner risk/safe storage) □ Water safety (tub						
		Head/Face/Fontanelles Eyes/Red reflex/Cover test Ears Nose	- Don't lea PLANS 1. Imm						
		Mouth/Gums	2. Sec 3 Follo					ח פר ח ח	
		Neck/Nodes Lungs	 3. Follow-up newborn hearing screen □ 4. Next preventive appointment □ 5. Referrals for identified problems? (specify) 						
		Heart/Pulses Chest/Breasts							
		Abdomen Genitals/Circumcision							
		Extremities/Hips/Feet Neuro/Reflexes/Tone		-					
		Vision (gross assessment) Hearing (gross assessment)	-						

Signatures:

PEDI	ATRIC	VISIT 2 to 3 MONTHS	4	DATE O	F SERVICE				
NAME			M/F	DATE OF BIRTH	AGE				
-		% HEIGHT/_			TEMP				
Perinat	health hi tal history	story documented & updated? v documented & updated?	<u>Breast/b</u> Bowel/b	TIONAL ASSESSMENT: <u>pottle</u> : Amount & frequency, <u>ladder</u> : Number of wet,					
PSYC Sleep: Materr Recen New m Loss of Enviro Violen History	HOSO nal Depre t change embers, f job, othe nment: S ce Asses of injurie	Smokers in home? Yes / No	Education If breast Growth s DEVEL Social: <u>Fine Mo</u> Languag	BM's in 24 hours? on: Hold to feed □ Use of pacifi fed, Vitamin D □ Feed on dema spurts □ Avoid solid foods until 4 _OPMENTAL SURVEILLA Regards face □ Alert □ Social s tor: Follows 90 degrees □ Gras ge: Coos □ Laughs □ <u>lotor</u> : Head steady when sitting	nd □ -6 months □ NCE: (<i>O</i> bserved or <i>R</i> eported) smile □ sps □				
<u>Risk A</u>	<u>ssessme</u> SICAL E	ent: TB Circle: Positive / Negative (Annual) EXAMINATION (describe abnormalities)	<u>Social</u> : Father's <u>Parentir</u>	IPATORY GUIDANCE: Time out for parent □ Parental a involvement □ ng: Comfort often □ Infant deve much of time when awake □					
		Skin Head/Face/Fontanelles Eyes/Red reflex/Cover test Ears	— Play and Talk or s <u>Health</u> :	aments differ among infants □ <u>d communication</u> : Infant seat □ sing to baby □ Objects to kick or Fever/taking temp □ Rashes □ hand smoke □	bat at □				
		Nose Mouth/Gums/Dentition Neck/Nodes Lungs	Injury pr Smoke c Hot wate Choking	 Second hand smoke □ Injury prevention: Rear riding/rear facing infant car seat □ Smoke detector/escape plan □ Hot liquids □ Poison control # □ Hot water set at 120° □ Water safety (tub/pool) □ Choking/suffocation □ Firearms (owner risk/safe storage) □ Fall prevention (heights) □ Don't leave unattended □ 					
		Heart/Pulses Chest/Breasts	1. Imm	S/ORDERS/REFERRALS					
		Abdomen Genitals	 2. Second metabolic screen, if not done earlier 3. Follow up newborn hearing screen 4. Next preventive appointment at 4 months 						
		Extremities/Hips/Feet Neuro/Reflexes/Tone	— 5. Refe 	errals for identified problems? (sp	есіту)				
		Vision (gross assessment) Hearing (gross assessment)							

Signatures: _____

PED		VISIT 4 to 5 MONTHS	5			DATE	OF SERVICE	
NAME			M/F	DATE	OF BIRTH		AGE	
		% HEIGHT/					TEMP	
Family Perina	atal history	istory documented & updated? y documented & updated?	Breast/	<u>bottle</u> : Am	-	uency	_, dry in 24 hours?	
		munizations? Yes / No	Number	BM's in 24	4 hours?		□ Iron in formula □	
<u>Sleep</u>	:	CIAL ASSESSMENT: Child care:	If breast	t fed, Vitan	nin D and ire gredient foo	on 🗆		
<u>Recent changes in family</u> : (circle all that apply) New members, separation, chronic illness, death, recent move, loss of job, other							ANCE: (Observed or R eported) ith parent □	
<u>Envir</u>	onment:	Smokers in home? Yes / No			ws 180 deg Hands tog		rasps rattle □	
	nce Asse	<u>ssment</u> : es, accidents? Yes / No	<u>Langua</u>	ge: Vocali	zes 🗆 Coo	s 🗆 Laugh	ns 🗆	
Evider <u>Risk /</u>	nce of neg Assessm	glect or abuse? Yes / No <u>ent:</u> TB Circle: Positive / Negative (Annual) EXAMINATION	Prone, I	ifts head 9			□ Lifts chest up □ eady when sitting □	
		Appearance/Interaction Growth	-	-	Y GUIDA s/daily routi	-	er 🗆	
		Skin	<u>Parenti</u>	ng : Can't	spoil 🗆 Diff	erent babi	es have different temperaments \Box	
		Head/Face Eyes/Red reflex/Cover test	Respon	d to baby's	nication: H s "conversat nape, size a	ion" 🗆 Ag	e appropriate toys 🛛	
		Ears Nose		Teething, hand smo		newing 🗆	Clean teeth 🗆	
		Mouth/Gums					ng infant car seat □ ids □ Poison control # □	
		Neck/Nodes Lungs	Hot wate Choking	er set at 12 g/suffocatio	20° □ Wate on □ Fireari	er safety (ti ms (owner		
		Heart/Pulses Chest/Breasts	PLAN	S/ORDE	RS/REFE	RRALS		
		Abdomen Genitals	 Immunizations by schedule Follow up newborn hearing screen Next preventive appointment at 6 months □ Referrals for identified problems? (specify) 					
		Extremities/Hips/Feet Neuro/Reflexes/Tone	4. Ref		uentinea pro		<i>сресну)</i>	
		Vision (gross assessment) Hearing (gross assessment)						

Signatures: _____

PEDIA		VISIT 6 to 8 MONTHS		6			DATE OF	= SERVICI	E
NAME			Μ	l/F		DATE OF BIRT	Ή	Α	GE
		% HEIGHT							
Perinata Reaction	nealth hisi Il history o ns to imm	tory documented & updated? documented & updated? uunizations? Yes / No		<u>Brea</u> Bow	ast/bott vel/blade	DNAL ASSESS le: Amount & frequent & frequence der: Number of we 's in 24 hours?	uency		
PSYCI <u>Sleep</u> : <u>Recent</u> New me	HOSOC <u>changes</u> mbers, se	CIAL ASSESSMENT: <u>Child care</u> : <u>in family</u> : (circle all that apply) eparation, chronic illness, death, recent mo		Offe Enc	r cup □ ourage s VELOF	Introduce single ir Jar/table foods self-feeding Onl ONENTAL SUP with strangers	Avoid sma ly water in b	II hard food edtime bot	ds □ ttle □ served or R eported)
Environ	i ment: Sr	mokers in home? Yes / No				: Transfers toy har f reach □	nd to hand ⊑] Feeds se	elf crackers □ Works
History of		a, accidents? Yes / No ect or abuse? Yes / No		Imita	ates spe	Dada or Mama (no ech sounds □ or: Sits alone □ Si	. ,		o voice 🗆
RISK /	ASSES	SMENT: TB (Annual) LEA	D			it on legs \Box No he		0	sitting
(Circle)		Pos / Neg Pos / Ne	eg	A NI		ATORY GUIDA			
PHYSI Wnl D D D D D D D D	Abn	XAMINATION (describe abnormalities) Appearance/Interaction Growth Skin Head/Face/Fontanelles Eyes/Red reflex/Cover test Ears Nose		Soc Pare Tem May Play Toys Beg Hea	ial: Fea enting: per tant need re <u>and co</u> s with m inning sp <u>Ith</u> : Fluc	ar of strangers Emphasize protect crums: ignore, distr eassurance for sep <u>ommunication</u> : W oving parts, holes, peech sounds pride if well water [Use sunscreen]	Separation a ction over dis cact paration anx dater and san strings to p Second h	scipline □ iety □ nd play □ pull □	e 🗆
		Mouth/Gums/Number of Teeth	_	Smo	oke dete	ention: Rear riding	Baby proc	of home □	seat 🗆
		Neck/Nodes Lungs	-	Cho Fire	king/suf arms (ov	et at 120° □ Poisc focation □ Fall pre wner risk/safe stora y (tub/pool) □ Dor	evention (he age) □ Hot	eights) □ liquids □	
		Heart/Pulses Chest/Breasts		PL	ANS/O	RDERS/REFE	RRALS		
		Abdomen Genitals	_	2. 3.	Lead te Follow u	zations ordered □ st, if positive risk a up newborn hearin	assessment ig screen □		
		Extremities/Hips/Feet Neuro/Reflexes/Tone	_	5.	Next pre	e Varnish Applied? eventive appointm Is for identified pro	ent at 9 mor	nths 🗆	
		Vision (gross assessment) Hearing (gross assessment)	_						

Signatures:_____

PED	IATRIC	VISIT 9 to 11 MONTHS	DATE OF SERVICE
NAME			M / F DATE OF BIRTH AGE
WEIGH	HT	/% HEIGHT/	% HC/% TEMP
Perina Reaction	health hi tal history ons to imi	story documented & updated? documented & updated? nunizations? Yes / No	NUTRITIONAL ASSESSMENT: <u>Breast/bottle</u> : Amount & frequency <u>Bowel/bladder</u> : Number of wet, dry in 24 hours? Number BM's in 24 hours? <u>Education</u> : Jar/table foods □ Offer cup □ Avoid small hard foods □
PSYC <u>Sleep</u> :		CIAL ASSESSMENT: <u>Child care</u> :	Encourage self-feeding/finger foods □ Expect messiness/playing with food □ Water only bedtime bottle □
New m	nembers,	<u>s in family</u> : (circle all that apply) separation, chronic illness, death, recent move,	DEVELOPMENTAL SCREENING: (With Standardized Tool) REQUIRED ASQ: PEDs Other: (specify)
<u>Enviro</u>	onment: S	Smokers in home? Yes / No	Results: WnI Areas of Concern:
History		s <u>ment</u> : s, accidents? Yes / No lect or abuse? Yes / No	Referred : Yes / No <u>Where</u> ? DEVELOPMENTAL SURVEILLANCE : (<i>Observed or Reported</i>) <u>Social</u> : Shy with strangers □ Plays patty cake □
RISK	ASSES	SMENT: TB (Annual) LEAD	Looks for fallen object
(Circle)	Pos / Neg Pos / Neg	<u>Fine Motor</u> : Bangs two cubes □ Pincer grasp □ Reaches, grabs □ Feeds self □ Drinks from cup □
PHYS Wnl D	Abn	EXAMINATION: (describe abnormalities) Appearance/Interaction Growth	Language: Dada or Mama (specific) Babbles Imitates speech sounds Gross Motor: Gets to sitting Pulls self to stand ANTICIPATORY GUIDANCE: (Check all that were discussed)
		Skin	<u>Social</u> : Fear of strangers □ Separation anxiety □ <u>Parenting</u> : Emphasize protection over discipline □
		Head/Face Eyes/Red reflex/Cover test Ears Nose Mouth/Dentition (# of teeth)	Temper tantrums: ignore, distract May need reassurance for separation anxiety Play and communication: Water and sand play Toys with moving parts, holes, strings to pull Beginning speech sounds Health: Fluoride if well water Second hand smoke Clean teeth with soft toothbrush or cloth Use sunscreen Injury prevention: Rear riding/rear facing infant car seat
		Lungs Heart/Pulses Chest/Breasts	Smoke detector/escape plan □ Poison control# □ Hot liquids □ Hot water set at 120° □ Water safety (tub, pool) □ Choking/suffocation □ Firearms (owner risk/safe storage) □ Fall prevention (heights) □ Baby proof home □
		Abdomen Genitals	Don't leave unattended
		Extremities/Hips/Feet Neuro/Reflexes/Tone	 Immunizations ordered □ Lead test referral (if positive risk assessment) □ Fluoride Varnish Applied? Yes / No
		Vision (gross assessment) Hearing (gross assessment)	 Next preventive appointment at 12 months □ Referrals for identified problems? (<i>specify</i>)

7

PEDIATRIC VISIT 12 to 14 MONTHS						⁸ DATE OF SERVICE					
NAME					Μ/	F DATE	OF BIRTH			AGE	
WEIGI	HT	/	% HEIGHT	/	%	HC	/	%	TEMP_		
Medica Family	al history health h	updated?	DATE: (note chang		<u>Typ</u>	bical diet : (s	AL ASSES pecify foods):			<i>"</i>	
Reacti	eactions to immunizations? Yes / No oncerns:					creased app	ase out bottle etite □ Whol ew foods □ 1	e milk unt	il age two [
PSY(Sleep:		CIAL ASSI	ESSMENT: Child care:						-	Standardized Tool)	
Recent changes in family: (circle all that apply) New members, separation, chronic illness, death, recent move, oss of job, other					Res	sults: Wnl ⊏	Areas of Co	ncern:			
/iolen	ce Asse	ssment:	ome? Yes / No				ENTAL SU			(O bserved or R eported)	
History Evider	v of injurie ice of neg	es, accidents? glect or abuse	? Yes / No ? Yes / No		Fin	e Motor: Sc	ribbles ⊡ Pir da or Mama (icer grasp	Drinks	from cup \Box	
RISK	ASSE	SSMENT:	ТВ	LEAD		cates wants		specific) L			
Circle)		Pos / Neg	Pos / Neg			Stands alone ys ball with e			$s \Box$ Stoops and	
Vnl]]	Abn □ □	Appearanc Growth	ponormalities) ee/Interaction		<u>Soc</u> Par	<u>cial</u> : Fear o r <u>enting</u> : Dela	DRY GUID f strangers □ ay toilet traini as to teach □	Separati ng □ Neg	gativism □	Autonomy 🗆	
		Ears	e reflex/Cover test		<u>Pla</u> Sing <u>Hea</u>	y and comr ging, naming alth: Fever	nunication: \	/aried act well wate	tivities □ er □ Brush		
			tal/Number of teeth	1	Hot	liquids 🗆 H		at 120º □	Water saf	seat □ ety (tub, pool) □ proof home □	
]		Neck/Node Lungs	25		Fire	earms (owne		orage) 🗆	Fall prever	tion (heights) □	
		Heart/Pulse Chest/Brea			PL 1.		DERS/REF				
		Abdomen Genitals			2. 3.	Lead test/F PPD, if pos	ICT required	□ essment []		
		Musculosk Neuro/Refl			4. 5. 6.	Dental visit Fluoride Va		1? Yes /	No		
			ss assessment) ross assessment)		7. 8.	Next preve	ntive appoint	ment at 1	5 months 🛙]	

PEDIA

PEDI	ATRIC	VISIT 15 to 17 MO	NTHS	9)			DATE OF	SERVICE	
NAME				M/F		DATE	OF BIRTH			AGE
		/% HEIGH								
HISTC Medica Family Reactio	DRY RE I history u health his	EVIEW/UPDATE: (note updated? story updated? munizations? Yes / No	changes)	NU <u>Typ</u> <u>Edi</u>	JTF <u>pica</u> uca	RITION al diet (s ation: Or	IAL ASS specify foods nly water in	ESSMENT ;):	Γ: ttle ⊡ Keep	offering new foods
<u>Sleep</u> : <u>Recent</u> New me loss of j	t change embers, s job, other	CIAL ASSESSMENT: <u>Child</u> <u>s in family</u> : (circle all that a separation, chronic illness, r Smokers in home? Yes / No	<u>care</u> : oply) death, recent move,	AS(Res Ref DE Soc	<u>Q</u> : [sult ferr EVE cial	□ <u>PEDs</u> t <u>s</u> : Wnl [red: Yes ELOPN <u>l</u> : Imitate	□ <u>Other</u> : [□ <u>Areas of</u> ; / No <u>Wh</u> //ENTAL es affection	□ (specify) _ □ Concern : <u>ere</u> ?		Standardized Tool)
<u>Violence Assessment:</u> History of injuries, accidents? Yes / No Evidence of neglect or abuse? Yes / No					e N	es house <u>Iotor</u> : S of 2 cub	cribbles sp	ontaneously	□ Uses cu	$p \square$ Feeds self \square
	ASSES	SMENT: TB Pos / Neg	LEAD Pos / Neg	Poir Gro	ints oss	to 1-3 n Motor:	amed body Crawls up		iderstands s oops and rec	
PHYS Wnl	Abn	XAMINATION (describe abnormalities) Appearance/Interaction Growth		AN <u>Soc</u>	NTI cial	CIPAT I: Child i	ORY GU	IDANCE: ic Loves	-	
		Skin		Ten	mpe	er tantrui	ms: ignore,		Avoid spanki	ing/slapping □ nomy needs □
		Head/Face Eyes/Red reflex/Cover to Ears Nose	est	<u>Pla</u> Like	i <u>y a</u> es t	nd com to push/p	municatio	<u>n</u> : Climbing fill, open/clo	, dancing, ri	ding toys □
		Mouth/Dental/Number of	teeth	Tee	eth	brushing	g 🗆 Fluoric	ng illness/str le if well wat lse sunscree	er 🗆	er shoes □
		Lungs Heart/Pulses		<u>Inju</u> Bab	ury by p	prevent proof hor	<u>tion</u> : Infan me □ Hot I	t car seat □ iquids □ Ho	Rear riding	
		Chest/Breasts		Fire	earr	ms (own	er risk/safe		Fall prevent	tion (heights) 🗆
		Genitals						EFERRAL		
		Musculoskeletal Neuro/Reflexes/Tone		1. 2. 3.	Re Re	eview lea efer for l	ad and HC ead and H(T results □ _ CT testing if	not available	e 🗆
		Vision (gross assessme Hearing (gross assessm		4. 5. 6. 7.	De Fl	ental vis uoride V	it advised [/arnish App	lied? Yes	ast dental e	xam
Signati										

PE

PEDI	ATRIC	VISIT 18 t	o 23 MONT	HS	10)			DATE	OF SERVICE
						DATE OF	BIRTH			AGE
WEIGH	ΗT		% HEIGHT_	/	%	HC		/	_%	TEMP
Medica Family Reaction	al history health hi ons to im	updated? story updated? munizations? እ	/es / No		<u>Typ</u> Edu	TRITION	olonged m	nealti	me with pl	aying □ I jags okay □
Conce	rns:					w self-feedi				
<u>Sleep</u> :		CIAL ASSE	<u>(</u>	Child care:	REC	UIRED				G: (With Standardized Tool)
New m		separation, chi	<i>ircle all that apply)</i> ronic illness, dea	ith, recent move,	Res	sults: Wnl	Areas of	f Cor	ncern:	
Enviro Violen History	onment: S ce Asse	Smokers in hor	Yes / No		<u>MCI</u> DE Soc Imita	HAT Requin VELOPM cial: Remove ates housev	red □ IENTAL es clothes work □	SUI ₀ _	RVEILL/ lelps with	ANCE:(Observed or R eported simple tasks □
RISK	ASSES	SSMENT:	ТВ	LEAD						cubes □ Turns pages □ s to 2-4 named body parts □
(Circle)			Pos / Neg	Pos / Neg	Foll		ons 🗆 Nar			t, bird, horse, dog, person) \Box
Wnl	Abn □ □	EXAMINATIC (describe abn Appearance Growth Skin	ormalities)		Wal AN Soc	ks backwar TICIPAT(d	JIDA	NCE:	□ Walks up steps □ ubbornness is normal □
		Head/Face	flex/Cover test		<u>Par</u> Chil "Tin	enting: Dai d constantly ne out" for h	ly routines y tests par itting/bitin	rent,⊧ g □	self, siblin Avoid spa	needs □ gs, environment □ nking, slapping □ □ Give choices □
		Nose Mouth/Denti Neck/Nodes	tion (# of teeth)		Mar Thu	nipulative to mb sucking	ys (play d and mast	ough turba	i, sand, pa tion comm	s for imaginary play □ int) □ Read stories □ ion □
		Lungs			Hea	orite toy, tra <u>alth</u> : May be cond hand s	e toilet rea	, ndy ⊡	Brush tee	eth □ Fluoride if well water □
		Heart/Pulses Chest/Breas			<u>Inju</u>	iry preventi	ion: Infan	t car	seat 🗆 Re	⊐ ear riding seat □ /ater safety (tub, pool) □
		Abdomen Genitals			Pois Fire	son control i arms (owne	no.	oking e stor	/suffocatio age) □ Fa	on □ Baby proof home □ all prevention (heights) □ or/escape plan □
		Extremities/I Neuro/Refle			PL	ANS/ORE	DERS/R	EFE	RRALS	
			s assessment) oss assessment)		2. 3. 4.	Review Lea PPD, if risk Fluoride Va Dental visit Next preve	ad and H(assessm arnish App t advised f entive appo	CT re nent p blied? or ointm	sults □ R positive □ ? Yes / I date of las nent at 2 Y	t dental visit ears □
					7.	Referrals for	or identifie	ed pro	oblems: (s	pecify)

Signatures:

PEDIATRIC VI	ISIT 2 YEARS	DATE OF SERVICE
NAME		M / F DATE OF BIRTH AGE
WEIGHT	_/% HEIGHT/	% BMI/% TEMP
Medical history upd Family health histor Reactions to immur Concerns: PSYCHOSOCIA Sleep: Recent changes in New members, sep	EW/UPDATE: (note changes) ated? y updated? nizations? Yes / No AL ASSESSMENT: <u>Child care</u> : <u>h family</u> : (circle all that apply) aration, chronic illness, death, recent move,	NUTRITIONAL ASSESSMENT: Typical diet: (specify foods): Education: Offer variety of nutritious foods □ 5 fruits/vegetables daily □ Child sized portions □ Avoid struggles over eating □ Eat with family □ DEVELOPMENTAL SCREENING: (With Standardized Tool) REQUIRED ASQ: □ PEDs □ Other: □ (specify) Results: Wnl □ Areas of Concern: Referred: Yes / No Where?
•	okers in home? Yes / No	<u>MCHAT</u> Required □
Violence Assessm History of injuries, a	ient:	DEVELOPMENTAL SURVEILLANCE : (<u><i>Observed or Reported</i></u>) <u>Social:</u> Helps with simple tasks \Box Puts on clothing \Box Brushes teeth \Box Washes and dries hands \Box Plays interactive games \Box Separates from mother \Box
RISK ASSESSI (Circle)	MENT: CHOL TB LEAD Pos / Neg Pos / Neg Pos / Neg	<u>Fine Motor:</u> Scribbles □ Tower of 4-6 cubes □ Copies vertical line □ Uses spoon well □
PHYSICAL EXA Wnl Abn (a	AMINATION: describe abnormalities)	Language: Combines 2 words □ Knows 3-5 named body parts □ Follows 2 part directions □ Understands cold, tired, hungry □ Gives first and last name □ Picks longer line □
	ppearance/Interaction Growth	Names 1 picture (cat, bird, horse, dog, person) □ <u>Gross Motor:</u> Kicks ball □ Runs well □ Walks up steps □ Jumps □ Balances on 1foot-1 second □ Pedals tricycle □ Throws ball overhand □
	kin	
	lead/Face iyes/Red reflex/Cover test ars lose louth/Gums/Dentition	ANTICIPATORY GUIDANCE: (Check all that were discussed) Social: Aware of self/different from others Needs peer contact Dawdling is normal Resolving negativism Power struggles occur Parenting: Toilet training (relaxed, praise success) Sexuality Help teach self-control Offer choice, give simple tasks Tantaurae (ispace distant summathing)
	leck/Nodes	Tantrums (ignore, distract, sympathize) □ <u>Play and communication:</u> Small table and chairs □
	ungs	Stories and music \Box Building materials \Box
	leart/Pulses hest/Breasts	<u>Health:</u> Avoid bubble baths □ Night fears □ Brush teeth □ Fluoride if well water □ Biting, kicking stage □ Use sunscreen □ Physical activity □ Second hand smoke □ Tick prevention □
	bdomen Senitals	Injury prevention: Car seat □ Rear riding seat □ Poison control # □ Hot water at 120° □ Water safety (tub, pool) □ Toddler proof home □ Smoke detector/escape plan □ Hot liquids □ Choking/suffocation □ Firearms (owner risk/safe storage) □ Fall prevention (heights) □
	xtremities/Hips/Feet leuro/Reflexes/Tone	PLANS 1. Review immunizations and bring up to date □ 2. Second Lead/HCT test required □
— — н — — — — — — — — — — — — — — — — —	ision (gross assessment) learing (gross assessment)	 Speech referral if delayed
		9. Referrals for identified problems? (specify)

PEDI	ATRIC	VISIT 30 MONTHS	12 DATE OF SERVICE
NAME_			M / F DATE OF BIRTH AGE
WEIGH	IT	/% HEIGHT/	% BMI/% TEMP
Medica Family Reactio	l history u health his ons to imn	VIEW/UPDATE: (note changes) pdated? tory updated? nunizations? Yes / No	NUTRITIONAL ASSESSMENT: Typical diet: (specify foods): Education: Offer variety of nutritious foods □ 5 fruits/vegetables daily Child sized portions □ Avoid struggles over eating □ Eat with family □
PSYC Sleep: Recent New me loss of j Environ Violenc History Evidenc	t changes embers, s job, other <u>nment:</u> S <u>ce Asses</u> of injuries ce of negl	CIAL ASSESSMENT: <u>Child care</u> : <u>s in family</u> : (circle all that apply) eeparation, chronic illness, death, recent move, mokers in home? Yes / No <u>sment</u> : s, accidents? Yes / No ect or abuse? Yes / No	DEVELOPMENTAL SCREENING: (With Standardized Tool) REQUIRED if not completed at 24 month visit ASQ: □ PEDs □ Other: □ (specify)
(Circle)		SMENT: CHOL TB LEAD Pos / Neg Pos / Neg Pos / Neg XAMINATION: (describe abnormalities)	Uses spoon well □ <u>Language:</u> Combines 2 words □ Knows 3-5 named body parts □ Follows 2 part directions □ Understands cold, tired, hungry □ Gives first and last name □ Picks longer line □ Names 1 picture (cat, bird, horse, dog, person) □
		Appearance/Interaction Growth	Gross Motor: Kicks ball □ Runs well □ Walks up steps □ Jumps □ Balances on 1foot-1 second □ Pedals tricycle □ Throws ball overhand □
		Skin Head/Face Eyes/Red reflex/Cover test	ANTICIPATORY GUIDANCE: (Check all that were discussed) Social: Aware of self/different from others Needs peer contact Dawdling is normal Resolving negativism Power struggles occur
		Ears Nose Mouth/Gums/Dentition	Parenting: Toilet training (relaxed, praise success) □ Sexuality □ Help teach self-control □ Offer choice, give simple tasks □ Tantrums (ignore, distract, sympathize) □ Play and communication: Small table and chairs □
		Neck/Nodes Lungs	Stories and music □ Building materials □ <u>Health:</u> Avoid bubble baths □ Night fears □ Brush teeth □ Fluoride if well water □ Biting, kicking stage □ Use sunscreen □
		Heart/Pulses Chest/Breasts	Physical activity Second hand smoke Tick prevention Injury prevention: Car seat Rear riding seat Poison control # Hot water at 120° Water safety (tub, pool) Toddler proof home Smalls detector access plan Hot lignide Chaling (outfined to the lignide to the lignidet to the lignide to the lignide to the lignide t
		Abdomen Genitals	Smoke detector/escape plan □ Hot liquids □ Choking/suffocation □ Firearms (owner risk/safe storage) □ Fall prevention (heights) □ PLANS
		Extremities/Hips/Feet Neuro/Reflexes/Tone	 Review immunizations and bring up to date □ Second Lead/HCT test required □ if not completed at 24 month visit
		Vision (gross assessment) Hearing (gross assessment)	 Speech referral if delayed □ PPD, if risk assessment is positive □ Dental visit advised □ Date of Last Dental Exam Testing/counseling, if cholesterol risk assessment is positive Fluoride Varnish Applied? Yes / No Next preventive appointment at 3 Years □
Signati	ures:		9. Referrals for identified problems? (specify)

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PEDIATRIC VISIT 3 YEARS	¹³ DATE OF SERVICE
	M / F DATE OF BIRTH AGE
WEIGHT/% HEIGHT/	% BMI/% TEMP BP
HISTORY REVIEW/UPDATE: (note changes) Medical history updated? Family health history updated? Reactions to immunizations? Yes / No	 <u>Typical diet</u> (specify foods): <u>Education</u>: Offer variety of nutritious foods/snacks □ May be picky □
Concerns:	 Eats same foods as family □ 5 fruits/vegetables daily □ No sweetened beverages □
PSYCHOSOCIAL ASSESSMENT: <u>Sleep</u> : <u>Child care</u> : Decent charges in family: (sink all that cank)	DEVELOPMENTAL SCREENING: (With Standardized Tool) <u>ASQ</u> : Descript Descri
<u>Recent changes in family</u> : (circle all that apply) New members, separation, chronic illness, death, recent move loss of job, other	
Environment: Smokers in home? Yes / No	DEVELOPMENTAL SURVEILLANCE : (<i>Observed or Reported</i>) <u>Social</u> : Dresses self Separates easily Plays interactive games
Violence Assessment:	<u>Fine Motor</u> : Copies: O + □
History of injuries, accidents? Yes / No Evidence of neglect or abuse? Yes / No	Language: Understands 2of 3: cold, tired, hungry □ Understands 3 of 4 prepositions (block is on, under, behind in front of
RISK ASSESSMENT: CHOL TB LEAD	D table) □ Speech clear to examiner □ Recognizes 3-4 colors □
(Circle) Pos / Neg Pos / Neg Pos / Neg	eg Gross Motor: Balances on 1 foot for 1 second □ Jumps well □
MENTAL HEALTH ASSESSMENT: Problem identified? Yes / No	Broad jump 🗆 Pedals tricycle 🗆
Counseling provided? Yes / No	ANTICIPATORY GUIDANCE:
Referral? Yes / No To: PHYSICAL EXAMINATION	rivalry □ Develops pride with accomplishments □ Caution with strangers/animals □
Wnl Abn (describe abnormalities) Image:	Parenting: Time out for serious misbehavior □ Read parenting books □ Help child to release energy □ Avoid smacking, spanking □ Encourage talk about feelings (instead of misbehaving) □ Dependency needs alternate with independence □ Special times alone with child □ Praise child □
Head/Face Eyes/Red reflex	 Play and communication: Excursions, outdoor play, art □ Library □ Read to child □ Make up stories together □ Screen TV shows □
Cover test/Eye muscles Ears Nose Mouth/ Gums/Dentition	<u>Health</u> : Dental care □ Fears □ Physical activity □ Begin sex education (boy/girl differences, "private parts", etc) □ Masturbation □ Fluoride if well water □ Tick prevention □ Second hand smoke □ Use sunscreen □
Image: Neck/Nodes Image: Lungs	_ <u>Injury prevention</u> : Rear riding car seat □ Bicycle helmets □ Matches □ Riding toys in traffic □ Smoke detector/escape plan □ Poisoning (Plants, drugs, chemicals) □ Poison control # □
Heart/Pulses Chest/Breasts	_ Hot water 120° □ Choking/suffocation □ Fall prevention (heights) □ Firearms (owner risk/safe storage) □ Water safety (tub, pool) □ Toddler proof home □
Abdomen Genitals	PLANS/ORDERS/REFERRALS 1. Review immunizations and bring up to date 2. Review Lead and HCT results □ Refer for testing if none □
Image: Musculoskeletal Image: Musculoskeletal <t< td=""><td> PPD, if positive risk assessment □</td></t<>	 PPD, if positive risk assessment □
Image: Second system Vision (gross assessment) Image: Second system Hearing (gross assessment)	 6. Next preventive appointment at 4 Years □ 7. Referrals for identified problems:(<i>specify</i>)

Signatures:__

PEDIATRIC VISIT	4 TO 5	YEARS
NAME		

14

DATE OF SERVICE

•	 •••			
_	 	 	 	 _

WEIGHT/% HEIGHT	/	_%
HISTORY REVIEW/UPDATE: (note changes)		
Medical history updated? Yes / No		_
Family health history updated? Yes / No		
Reactions to immunizations? Yes / No		_
Concerns:		-

PSYCHOSOCIAL ASSESSMENT: Sleep:

Child care:

Recent changes in family: (circle all that apply) New members, separation, chronic illness, death, recent move, loss of job, other

Environment: Smokers in home? Yes / No

Violence Assessment:

History of injuries, accidents? Yes / No Evidence of neglect or abuse? Yes / No

RISK ASSESSMEN	NT: CHOL	ТВ	LEAD
(Circle)	Pos / Neg	Pos / Neg	Pos / Neg

(Circie)	Pos / Neg	Pos / Neg	POS/I

MENTAL HEALTH ASSESSMENT:

Problem identified?	Yes / No _	
Counseling provided?	Yes / No	
Referral? Yes / No		

PHYSICAL EXAMINATION

Wnl	Abn	<i>(describe abnormalities)</i> Appearance/Interaction Growth
		Skin
		Head/Face Eyes/Red reflex Cover test/Eye muscles Ears Nose Mouth/ Gums/Dentition
		Neck/Nodes Lungs
		Heart/Pulses Chest/Breasts
		Abdomen Genitals
		Musculoskeletal Neuro/Reflexes
		Vision (gross assessment) Hearing (gross assessment)

M/F	DATE O	F BIRTH_		 AC
b BN	/ IN	%	TEMP	

_____ AGE____

BP

NUTRITIONAL ASSESSMENT:

Typical diet: (specify foods):

Education: Choose from food guide pyramid
2hrs or less TV/day Child can help prepare food for meals D Mealtime can be fun D 5 fruits/vegetables daily
Food jags
1 or more hrs. physical activity

DEVELOPMENTAL SCREENING: (With Standardized Tool)

ASQ: □ PEDs □ Other: □ (specify) _____ Results: WnI
Areas of Concern:

Referred: Yes / No Where?

DEVELOPMENTAL SURVEILLANCE: (Observed or Reported)

Social: Toilets alone
Dresses self
Plays in group Separates from parent easily \Box

<u>Fine Motor</u>: Copies: O _____ + ____ □ ____ Uses scissors □ Draws person, 3 parts □

Language: Knows: What is:- spoon :; shoe ;; door ;; -made of? Fluent sentences
Recognizes 3-4 colors
Defines 6-9 words: Ball Lake Desk House Banana Curtain Ceiling Fence Knows 2-3 opposites: fire is hot, ice is \Box ; mom is woman, dad is \Box ; horse is big, mouse is

Gross Motor: Balances on 1 foot for 10 seconds (2-3 times) Hops
Heel-toe walk
Catches bounced ball

ANTICIPATORY GUIDANCE:

Social: School readiness

Enrolled in Pre-K/K

School avoidance Management of aggression
Promote self-help skills Caution with strangers/animals

Parenting: Allow separation
Promote initiative, creativity Awareness of ADHD and learning disabilities

Play and communication: Monitor TV use □ Small chores □ Creative, active and group play \Box

Health: Dental care \Box Fluoride if well water \Box Bedwetting \Box Fears \Box Nightmares
Leg aches
Normal sexual curiosity; simple answers Masturbation □ Oedipal complex □ Use sunscreen □ Tick prevention \Box Second hand smoke \Box

Injury prevention: Booster seat (up to 4'9") \Box Ride in back seat \Box Riding toys in traffic environment D Bicycle helmets D Matches D Choking/suffocation \Box Hot water 120° \Box Water safety (tub. pool) \Box Poisoning (Plants, drugs, chemicals)
Poison control # Fall prevention (playground) □ Smoke detector/escape plan □ Firearms (look alike toys, owner risk/safe storage)

PLANS/ORDERS/REFERRALS

- Review immunizations and bring up to date □_
- 2. Review Lead and HCT results
 Refer for testing if none
- PPD if positive risk assessment □______
 Testing/counseling if positive cholesterol risk assessment □______
- 5. Dental visit advised
 or date of last visit
- 6. Next preventive appointment at
- 7. Referrals for identified problems: Yes / No (specify)

PEDIATRIC VISIT 6 to 11 YEARS

NAME	<u> </u>	
WEIG	HT	/% HEIGHT/%
Medic Family React	al history y health h ions to im	EVIEW/UPDATE: (note changes) updated? istory updated? munizations? Yes / No
PSY <u>Child</u>		CIAL ASSESSMENT:
New n	nembers,	es in family: (circle all that apply) separation, chronic illness, death, recent move, er
<u>Envir</u>	onment:	Smokers in home? Yes / No
Histor		<u>ssment:</u> es, accidents? Yes / No glect or abuse? Yes / No
RISK		SSMENT: CHOL TB
(Circle)	Pos / Neg Pos / Neg
Couns	seling pro	ed? Yes / No vided? Yes / No / No To:
		EXAMINATION
Wnl	Abn □ □	(describe abnormalities) Appearance/Interaction Growth
		Skin
		Head/Face Eyes/Red reflex Cover test/Eye muscles Ears Nose/Mouth/Gums/Dentition
		Neck/Nodes Lungs
		Heart/Pulses Chest/Breasts
		Abdomen Genitals/Tanner stage
		Musculoskeletal Neuro/Reflexes
		Vision (gross assessment) Hearing (gross assessment)

BMI _____% TEMP_____ BP_____

DATE OF SERVICE

NUTRITIONAL ASSESSMENT:

Typical diet (specify foods):

Physical Activities:

15

At least 1hr. exercise daily? Yes / No

Education: Choose foods from food guide pyramid □ Sociable at table □ Lowfat food choices, including milk □ Choose healthy foods at school □ 5 fruits/vegetables daily □ No sweetened beverages □ 2hrs or less TV □

DEVELOPMENTAL SURVEILLANCE:

School: Grade: Performance:

Peer Relations:

Family Relations:

Extracurricular activities:

Misc. issues:

ANTICIPATORY GUIDANCE:

Social: Responsibility for self □, for school □ Competitiveness □ Family vs. peer activities □ Caution with strangers/animals □ Teach address and phone number □

<u>Parenting</u>: Increased autonomy in decisions □ Communicate □ Praise and encourage □ Give allowance □ Assist in handling money □ Establish fair rules □

<u>Play and communication</u>: Organized sports □ Hobbies □ Monitor TV use □

<u>**Health:**</u> Dental care □ Fluoride □ Personal hygiene □ Physical activity □ Smoking □ Second hand smoke □ Use sunscreen □ Tick prevention □

<u>Sexuality</u>: Prepare for physical changes □ Early sex education □ Masturbation □ Modesty □

Injury prevention: Seat belt □ Rear seat until age 12 years □ Riding toys in traffic environment □ Bicycle helmets □ Water safety □ Hot water 120° □ Fall prevention (playground) □ Matches □ Protective devices in sports □ Smoke detector/escape plan □ Poisoning (Plants, drugs, products) □ Poison control # □ Firearms (look alike toys; owner risk/safe storage) □

PLANS/ORDERS/REFERRALS

- Review immunizations and bring up to date □____
- 2. Objective Hearing and Vision Tests (recommended)_____
- 3. PPD, if positive risk assessment □_____
- Testing/counseling, if positive cholesterol risk assessment □_____
- Dental visit advised □ or date of last visit_____
- 6. Next preventive appointment at _____
- 7. Referrals for identified problems: Yes / No (specify)_____

PEDIATRIC VISIT 12 TO 13 YEARS

NAME_		
		/% HEIGHT/%
Medical Family h	history u lealth his	VIEW/UPDATE: (note changes) pdated? tory updated? unizations? Yes / No
Recent New me	changes	CIAL ASSESSMENT: <u>in family</u> : (circle all that apply) eparation, chronic illness, death, recent move,
<u>Environ</u>	i ment: Si	nokers in home? Yes / No
Any fear	s of partr	<u>sment</u> : (interview separately) her/other violence? Yes / No eapon? Yes / No
	•	ABUSE ASSESS/SCREENING:
Pos / No Referra	eg For:_ I: Yes/N	Counseled? Yes / No
Problem Counsel	identifie	ALTH ASSESSMENT: d? Yes / No ded? Yes / No No To:
	ASSES	SMENT: CHOL TB STI/HIV
(Circle)		
. ,	- · · · - ·	Pos/Neg Pos/Neg Pos/Neg
PHYSI	Abn	Pos / Neg Pos / Neg Pos / Neg XAMINATION (describe abnormalities) Appearance/Interaction Growth
PHYSI	Abn	XAMINATION (describe abnormalities) Appearance/Interaction Growth Skin
PHYSI	Abn	XAMINATION (describe abnormalities) Appearance/Interaction Growth Skin Head/Face Eyes/Red reflex
PHYSI	Abn	XAMINATION (describe abnormalities) Appearance/Interaction Growth Skin Head/Face Eyes/Red reflex Cover test/Eye muscles
PHYSI	Abn	XAMINATION (describe abnormalities) Appearance/Interaction Growth Skin Head/Face Eyes/Red reflex Cover test/Eye muscles Ears Nose
PHYSI	Abn	KAMINATION (describe abnormalities) Appearance/Interaction Growth Skin Head/Face Eyes/Red reflex Cover test/Eye muscles Ears Nose Mouth/Gums/Dentition
PHYSI	Abn	XAMINATION (describe abnormalities) Appearance/Interaction Growth Skin Head/Face Eyes/Red reflex Cover test/Eye muscles Ears Nose
PHYSI	Abn	XAMINATION (describe abnormalities) Appearance/Interaction Growth Skin Head/Face Eyes/Red reflex Cover test/Eye muscles Ears Nose Mouth/Gums/Dentition Neck/Nodes
PHYSI	Abn	KAMINATION (describe abnormalities) Appearance/Interaction Growth Skin Head/Face Eyes/Red reflex Cover test/Eye muscles Ears Nose Mouth/Gums/Dentition Neck/Nodes Lungs Heart/Pulses Chest/Breasts Abdomen Genitals/Tanner Stage/Pelvic/GU
PHYSI	Abn	KAMINATION (describe abnormalities) Appearance/Interaction Growth Skin Head/Face Eyes/Red reflex Cover test/Eye muscles Ears Nose Mouth/Gums/Dentition Neck/Nodes Lungs Heart/Pulses Chest/Breasts Abdomen

10	DATE OF SE	ERVICE	
M / F	DATE OF BIRTH	AGE	
BMI	% TEMP	BP	
NUTRI	TIONAL ASSESSMENT:		
Typical	diet: (specify foods):		

Symptoms of eating disorders? Yes / No

Physical Activities:

At least 1hr. exercise daily? Yes / No

Education: Choose variety of foods
Sociable at table Avoid fad diets/eating disorders □ Select healthy snacks □ 5 fruits/vegetables daily
2 hrs or less of TV/computer games

DEVELOPMENTAL SURVEILLANCE:

Name of School: Grade:	Performance:
Peer Relations:	
Family Relations:	
Extracurricular activities:	
Misc. issues:	

ANTICIPATORY GUIDANCE:

Social: Family and peer activities
Ownership and competition Responsibility for self and family
ETOH use
Drug Abuse

Parenting: Establish fair, negotiable rules
Money, allowance Promote mutual & self-respect
Respect privacy
Allow decisions Spend time with child talking, projects □

Play and communication: Organized sports Monitor TV and internet use

Health: Dental care \Box Fluoride \Box Personal hygiene \Box Smoking \Box Second hand smoke □ Use sunscreen □ Tick prevention □

Sexuality: Prepare for physical changes
Masturbation Modesty □ Sexual Responsibility □ STDs □

Injury prevention: Seat belt
Bicycle helmet
Riding in traffic Smoke detector/escape plan □ Poison control # □ Water safety □ Protective devices in sports
Alcohol/drug use Firearms (look alike toys; owner risk/safe storage) □

PLANS/ORDERS/REFERRALS

- Review immunizations and bring up to date □
- Recommend objective Hearing and Vision Tests □
- PPD if positive risk assessment □
- 4. Testing/counseling if positive cholesterol risk assessment □_____
- Testing if positive STD/HIV risk assessment □
- 6. Testing for sickle cell trait if original metabolic results not available
- Dental visit advised □ or date of last visit
- 8. Next preventive appointment at
- Referrals for identified problems: Yes / No (specify)_____

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PEDIATRIC VISIT 12 TO 13 YEARS

WEIGH	Γ	/% HEIGHT/%
Medical Family h Reaction	history u nealth his ns to imm	VIEW/UPDATE: (note changes) pdated? tory updated? nunizations? Yes / No
PSYCI <u>Recent</u> New me	HOSOC changes mbers, s	IAL ASSESSMENT: <u>in family</u> : (<i>circle all that apply</i>) eparation, chronic illness, death, recent move,
Violenc Any fear	e Assess rs of partr	mokers in home? Yes / No sment: (interview separately) her/other violence? Yes / No eapon? Yes / No
Pos / Ne	eg For:	ABUSE ASSESS/SCREENING: Counseled? Yes / No To:
Problem Counsel	identifie	ALTH ASSESSMENT: d? Yes/No ded? Yes/No No To:
RISK /	ASSES	SMENT: CHOL TB STI/HIV
(Circle)		Pos / Neg Pos / Neg Pos / Neg
PHYSI	-	Pos / Neg Pos / Neg Pos / Neg XAMINATION (describe abnormalities)
PHYSI	Abn	Pos / Neg Pos / Neg Pos / Neg XAMINATION (describe abnormalities) Appearance/Interaction
PHYSI	Abn	Pos / Neg Pos / Neg Pos / Neg KAMINATION (describe abnormalities) Appearance/Interaction Growth Skin Head/Face Eyes/Red reflex Cover test/Eye muscles Ears Nose
PHYSI	Abn	Pos / Neg Pos / Neg Pos / Neg CAMINATION (describe abnormalities) Appearance/Interaction Growth Skin Head/Face Eyes/Red reflex Cover test/Eye muscles Ears Nose Mouth/Gums/Dentition Neck/Nodes
PHYSI	Abn	Pos / Neg Pos / Neg Pos / Neg CAMINATION (describe abnormalities) Appearance/Interaction Growth Skin Head/Face Eyes/Red reflex Cover test/Eye muscles Ears Nose Mouth/Gums/Dentition Neck/Nodes Lungs Heart/Pulses Chest/Breasts Abdomen Genitals/Tanner Stage/Pelvic/GU
PHYSI	Abn	Pos / Neg Pos / Neg Pos / Neg CAMINATION (describe abnormalities) Appearance/Interaction Growth Skin Head/Face Eyes/Red reflex Cover test/Eye muscles Ears Nose Mouth/Gums/Dentition Neck/Nodes Lungs Heart/Pulses Chest/Breasts Abdomen

17	DATE O	F SERVICE
M / F	DATE OF BIRTH	AGE
BMI	/% TEMP	BP
-	TIONAL ASSESSME	NT:

Symptoms of eating disorders? Yes / No

Physical Activities:

At least 1hr. exercise daily? Yes / No

Education: Choose variety of foods □ Sociable at table □ Avoid fad diets/eating disorders □ Select healthy snacks □ 5 fruits/vegetables daily □ 2 hrs or less of TV/computer games □

DEVELOPMENTAL SURVEILLANCE:

Name of School: Grade:	Performance:
Peer Relations:	
Family Relations:	
Extracurricular activities:	
Misc. issues:	

ANTICIPATORY GUIDANCE:

Social: Family and peer activities □ Ownership and competition □ Responsibility for self and family □ ETOH use □ Drug Abuse □

<u>Parenting</u>: Establish fair, negotiable rules □ Money, allowance □ Promote mutual & self-respect □ Respect privacy □ Allow decisions □ Spend time with child talking, projects □

<u>Play and communication</u>: Organized sports □ Monitor TV and internet use □

<u>Health</u>: Dental care □ Fluoride □ Personal hygiene □ Smoking □ Second hand smoke □ Use sunscreen □ Tick prevention □

<u>Sexuality</u>: Prepare for physical changes □ Masturbation □ Modesty □ Sexual Responsibility □ STDs □

Injury prevention: Seat belt □ Bicycle helmet □ Riding in traffic □ Smoke detector/escape plan □ Poison control # □ Water safety □ Protective devices in sports □ Alcohol/drug use □ Firearms (look alike toys; owner risk/safe storage) □

PLANS/ORDERS/REFERRALS

- Review immunizations and bring up to date □_____
- 2. Recommend objective Hearing and Vision Tests □_____
- 3. PPD if positive risk assessment □_____
- 4. Testing/counseling if positive cholesterol risk assessment □_____
- 5. Testing if positive STD/HIV risk assessment □_____
- 6. Testing for sickle cell trait if original metabolic results not available \square
- Dental visit advised □ or date of last visit_____
- 8. Next preventive appointment at ____
- 9. Referrals for identified problems: Yes / No (specify)_____

Signatures:_____

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PEDIATRIC VISIT 1	14 TO 16 YEARS
NAME	

PSYCHOSOCIAL ASSESSMENT:

Recent changes in family: (circle all that apply)

Environment: Smokers in home? Yes / No

Violence Assessment: (interview separately) Any fears of partner/other violence? Yes / No

Access to gun/weapon? Yes / No

Referral: Yes / No To:

PHYSICAL EXAMINATION

Skin

Ears

Nose

Lungs

Head/Face

Neck/Nodes

Heart/Pulses

Eves/Red reflex

Abn

Π

Π

RISK ASSESSMENT: CHOL

MENTAL HEALTH ASSESSMENT:

HISTORY REVIEW/UPDATE: (note changes)

Medical history updated? Yes / No______ Family health history updated? Yes / No______

Reactions to immunizations? Yes / No

Concerns:

New members, separation, chronic illness, death, recent move,

SUBSTANCE ABUSE ASSESS/SCREENING: Pos / Neg For: _____ Counseled? Yes / No

Problem identified? Yes / No _____

Counseling provided? Yes / No _____

Referral? Yes / No To: _____

(describe abnormalities)

Appearance/Interaction

Cover test/Eye muscles

Mouth/Gums/Dentition

Growth (symptoms of eating disorders?)

ΤВ

Pos / Neg Pos / Neg Pos / Neg

STI/HIV

loss of job, other

(Circle)

Wnl

Π

Π

Π

Π

Π

Π

18	

M/F

WEIGHT_____% HEIGHT_____% BMI ____/ % TEMP_____

VICE_

RP	

Nutritional Assessment:

DATE OF BIRTH

Typical diet (specify foods):

Symptoms of eating disorder? Yes / No

Physical Activities:

At least 1hr. exercise daily? Yes / No

Education: Food sources of iron, calcium, folic acid Select healthy foods
Prevent obesity
Eat breakfast Avoid eating disorders/fad diets □ 2 hrs or less of TV/computer games □ 5 fruits/vegetables daily □ No sweetened beverages □

DEVELOPMENTAL SURVEILLANCE:

Name of School: Grade:	Performance:
Peer Relations:	
Family Relations:	
Extracurricular activities:	

Misc. issues:

ANTICIPATORY GUIDANCE:

Social: Confidentiality
Peer group pressures
Mood swings Dependence vs. independence Establishing own values Social misconduct due to family dysfunctions
Future plans Stay in school
Love life
ETOH use
Drug Abuse

Parenting: Establish fair, negotiable rules
Allow decisions Provide support, encouragement
Money, allowance Promote mutual respect
Respect privacy

Health: Dental care □ Personal hygiene □ Fluoride □ Menstruation □ Breast/testicular self-exam
Smoking
Second hand smoke
Use sunscreen
Tick prevention

Sexuality: Prepare for physical changes \Box Birth control \Box STDs \Box Sexual Responsibility

Injury prevention: Seat belt
Alcohol/drug use
Bicycle helmets Protective devices in sports
Water safety Smoke detector/escape plan □ Firearms (owner risk/safe storage) □

PLANS/ORDERS/REFERRALS

- 1. Review immunizations and bring up to date □_____
- 2. PPD, if positive risk assessment
- 3. Recommend Objective Hearing and Vision Tests □_____
- 4. Testing/counseling if positive cholesterol risk assessment □
- 5. Testing if positive STD/HIV risk assessment □_____
- Dental visit advised □ or date of last visit
- 7. Next preventive appointment at
- 8. Referrals for identified problems: Yes / No (specify)

Abdomen
Genitals/Tanner Stage/Pelvic/GU
Age at menarche LMP
Musculoskeletal
Neuro/Reflexes

Π Vision (gross assessment) \square Hearing (gross assessment)

Signatures:

https://mmcp.dhmh.maryland.gov/epsdt

PEDIATRIC	C VISIT 17 TO 20 YEARS	19	9	DATE OF SER	VICE
NAME	N	// F	DATE OF BIF	RTH	AGE
	/% HEIGHT/%	BMI		_% TEMP	BP
Medical history Family health h Reactions to im	EVIEW/UPDATE: (note changes) updated? nistory updated? nmunizations? Yes / No	<u>Typ</u> Syn <u>Phy</u>	<u>bical diet</u> (specify nptoms of eating /sical Activities	g disorder? Yes / No	
PSYCHOSC <u>Recent chang</u> New members, loss of job, othe	DCIAL ASSESSMENT: <u>es in family</u> : (circle all that apply) , separation, chronic illness, death, recent move, er	<u>Edu</u> Avo 5 fru	ucation: Select bid fad diets □ 2 uits/vegetables	hrs or less of TV/comp daily □ No sweetened b	0
	Smokers in home? Yes / No	DE		TAL SURVEILLAN	CE:
<u>Violence Assessment</u> : (interview separately) Any fears of partner/other violence? Yes / No Access to gun/weapon? Yes / No		Gra	me of School: ide: er Relations:	Perform	nance:
Pos / Neg For	E ABUSE ASSESS/SCREENING: :: Counseled? Yes / No / No To:	<u>Fan</u> Ext	nily Relations: racurricular ac	tivities:	
	SSMENT: CHOL TB STI/HIV	<u>Mis</u>	<u>c. issues</u> :		
(Circle)	Pos/Neg Pos/Neg Pos/Neg			Y GUIDANCE:	
MENTAL HE Problem identif	EALTH ASSESSMENT: fied? No / Yes Counseling provided? No / Yes	Soc	cial misconduct i	Peer groups pressures resulting from family dys alues Future plans	functions
Referral? No	/ Yes To:	<u>Par</u>	enting: Suppor	t Prepare for indepen	dence 🗆
Wnl Abn	EXAMINATION (describe abnormalities) Appearance/Interaction	Sec	cond hand smok		I hygiene □ Smoking □ east/testicular self-exam □ prevention □
	Growth	Sex	cuality: Birth co	ntrol 🗆 Sexual Respons	ibility 🗆 STDs 🗆
	Skin Head/Face Eyes/Red reflex Cover test/Eye muscles	Pro	tective devices	Seat belt □ Bicycle he n sports □ Smoke dete k/safe storage) □ Alcoh	ctor/escape plan □
	Ears			S/REFERRALS	
	Nose Mouth/Gums/Dentition	1. 2.			date □
		2. 3.			ol risk assessment
	Neck/Nodes Lungs	4.	Testing if posit	ive STD/HIV risk assess	ment 🗆
					sit 🗆
	Heart/Pulses Chest/Breasts	7.	Referrals for id	entified problems: Yes /	No (specify)
	Abdomen Genitals/Tanner Stage/Pelvic/GU				
	Age at menarche LMP Musculoskeletal Neuro/Reflexes				
	Vision (gross assessment) Hearing (gross assessment)				
Signatures:					



Control and Prevention CDC 24/7: Saving Lives, Protecting People™

BMI Percentile Calculator for Child and Teen **English Version**

This calculator provides BMI and the corresponding BMI-for-age percentile on a CDC BMI-for-age growth chart. Use this calculator for children and teens, aged 2 through 19 years old. For adults, 20 years old and older, use the Adult BMI Calculator

(http://www.cdc.gov/healthyweight/assessing/bmi/adult_BMI/english_bmi_calculator/bmi_calculator.htm 1).

Measuring Height and Weight Accurately At Home (http://www.cdc.gov/healthyweight/assessing/bmi/childrens_BMI/measuring_children.html)

BMI Calculator for Child and Teen

(English | Metric (Calculator.aspx?CalculatorType=Metric))

1. Birth Date:

	}	(1		
Month	•	Day	•	Year	
	J	C		L	

2. Date of Measurement:

the second s	 £		
Month	Day	V	Year
	 1 C		

3. Sex:

O Boy O Girl

4. Height, to nearest 1/8 inch:

Feet Inches Fractions of an inch 0 0 0 V ₹

(12 inches = 1 foot; Example: 4 feet, 5 1/2 inches)

5. Weight, to nearest 1/4 (.25) pound:

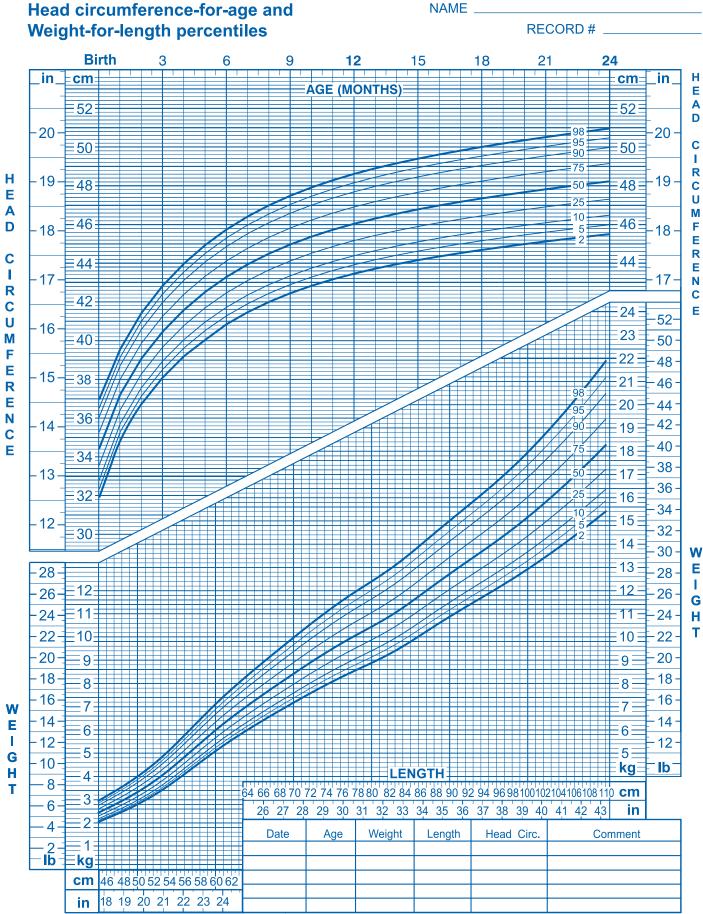
Weight (pounds): Fractions of a pound:

0 0 V 21 (8 ounces = 1/2 pounds; Example: 75 3/4 pounds)

Calculate

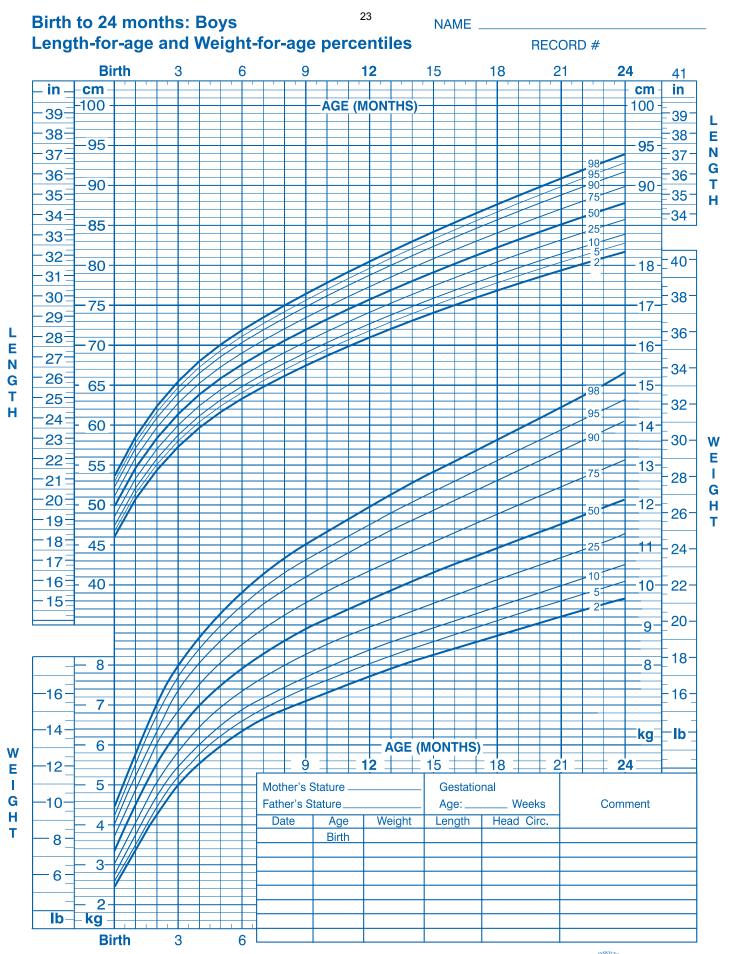
Note: Please keep in mind that this BMI calculator is not meant to serve as a source of clinical guidance and is not intended to be a substitute for professional medical advice. Because BMI is based on weight and height, it is only an indicator of body fatness. Individuals with the same BMI may have different amounts of body fat. Persons may consider seeking advice from their health-care providers on healthy weight status and to consider individual circumstances.





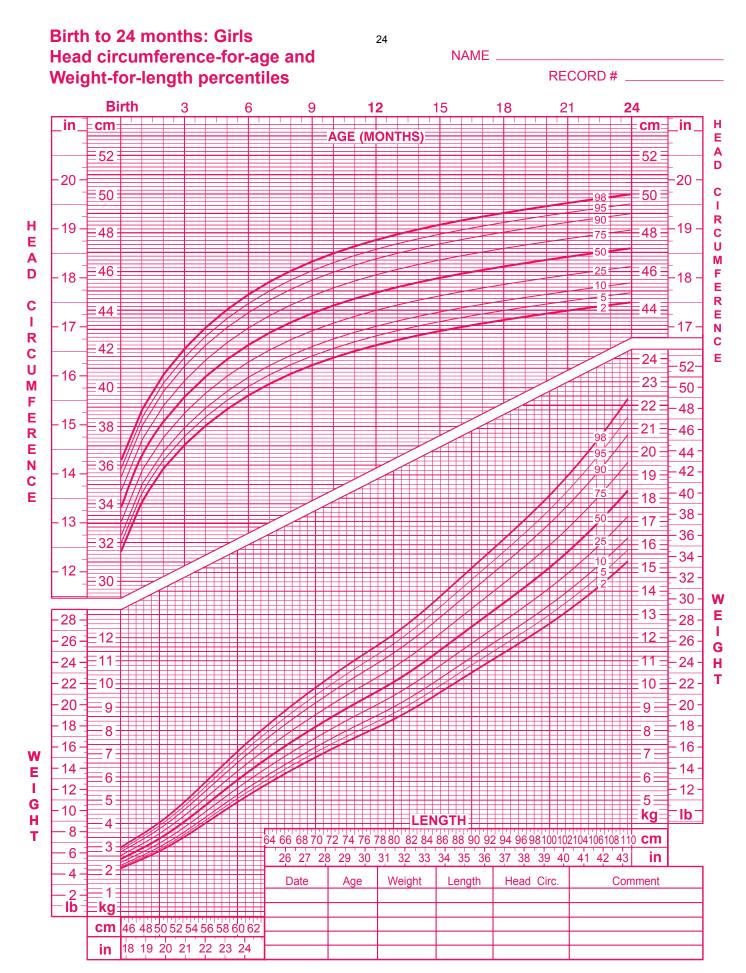
Published by the Centers for Disease Control and Prevention, November 1, 2009 SOURCE: WHO Child Growth Standards (http://www.who.int/childgrowth/en)





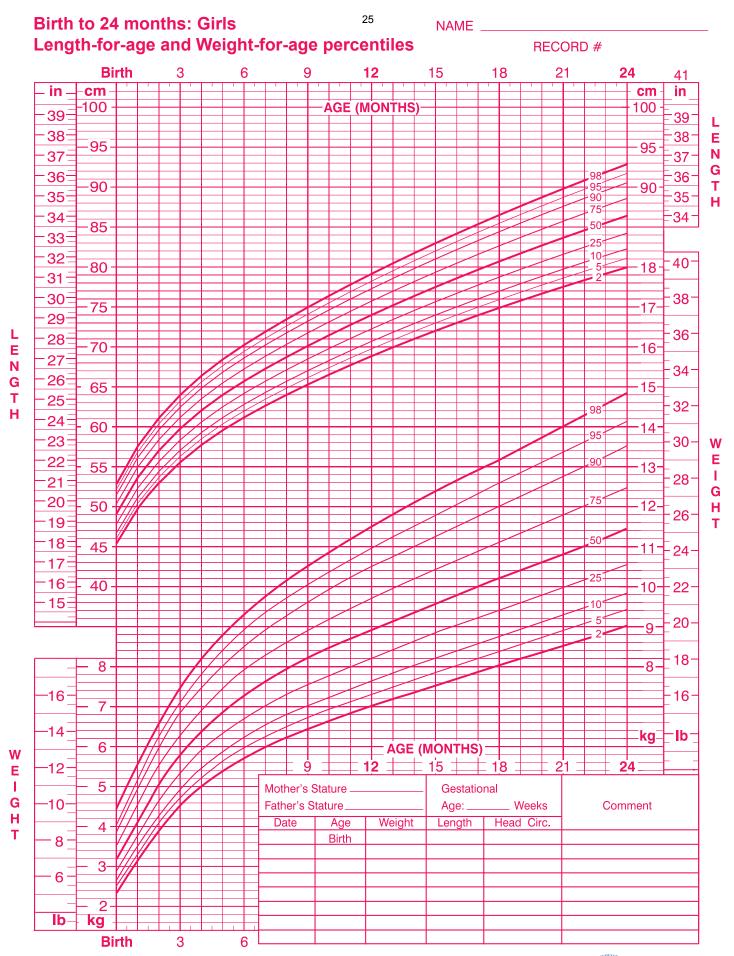






Published by the Centers for Disease Control and Prevention, November 1, 2009 SOURCE: WHO Child Growth Standards (http://www.who.int/childgrowth/en)





Published by the Centers for Disease Control and Prevention, November 1, 2009 SOURCE: WHO Child Growth Standards (http://www.who.int/childgrowth/en)



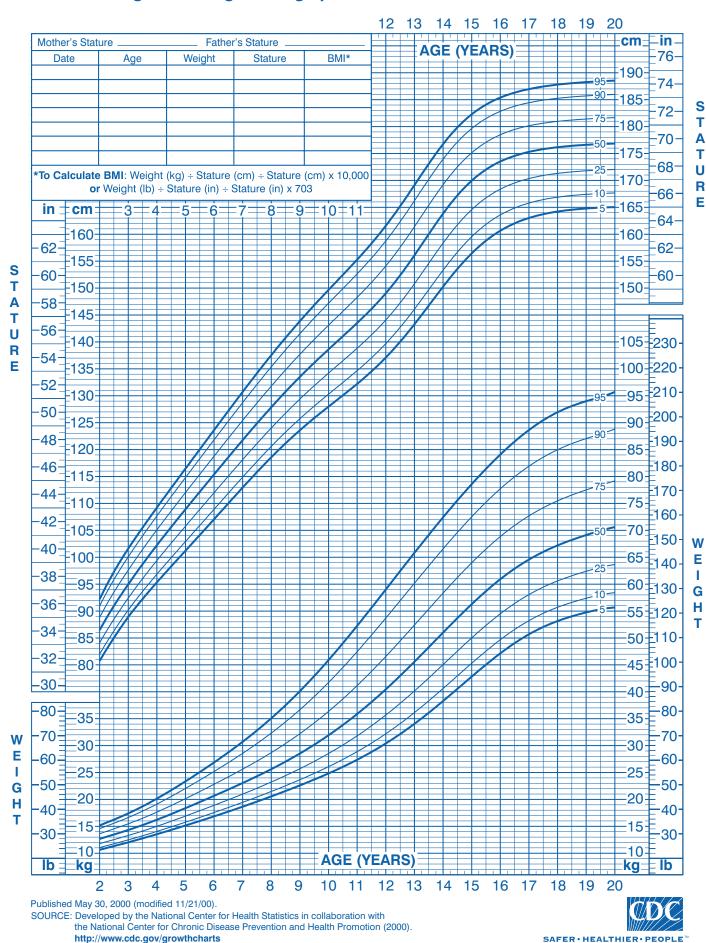
2 to 20 years: Boys

NAME .

RECORD #

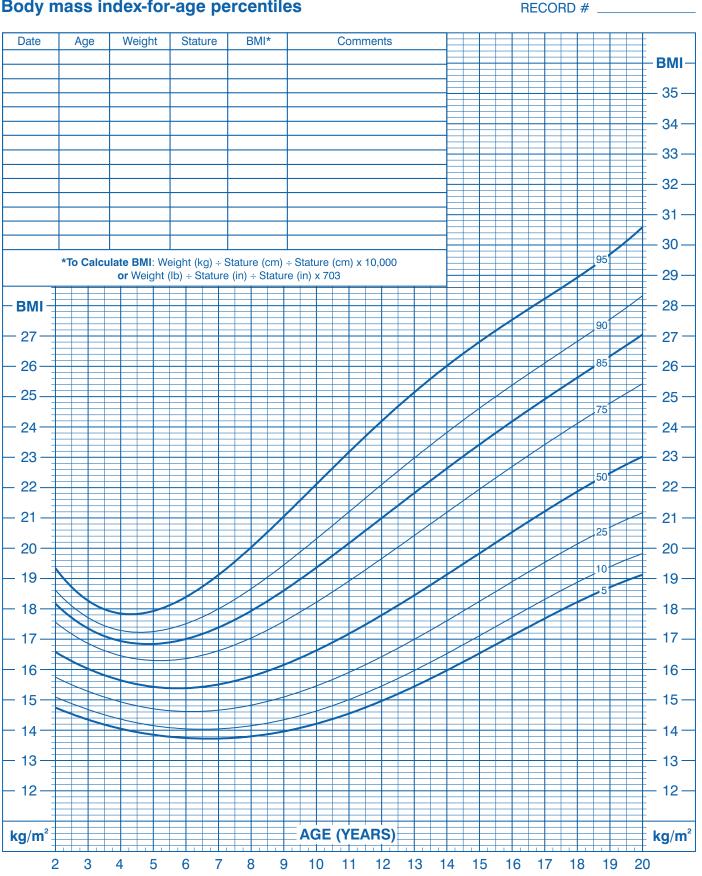
26





2 to 20 years: Boys Body mass index-for-age percentiles

NAME ___



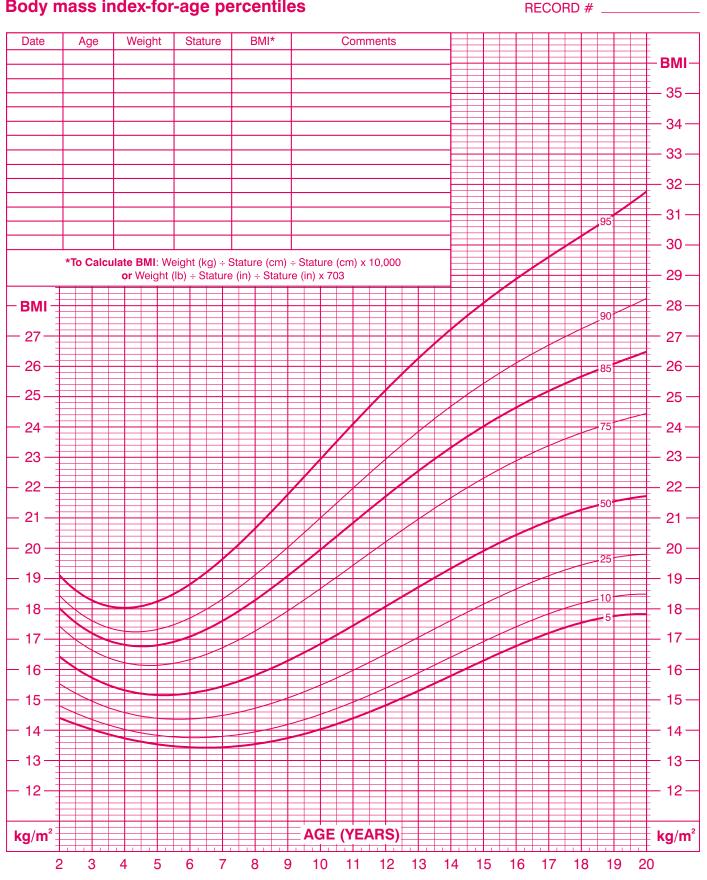
Published May 30, 2000 (modified 10/16/00).

SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000). http://www.cdc.gov/growthcharts



2 to 20 years: Girls Body mass index-for-age percentiles

NAME _____



Published May 30, 2000 (modified 10/16/00).

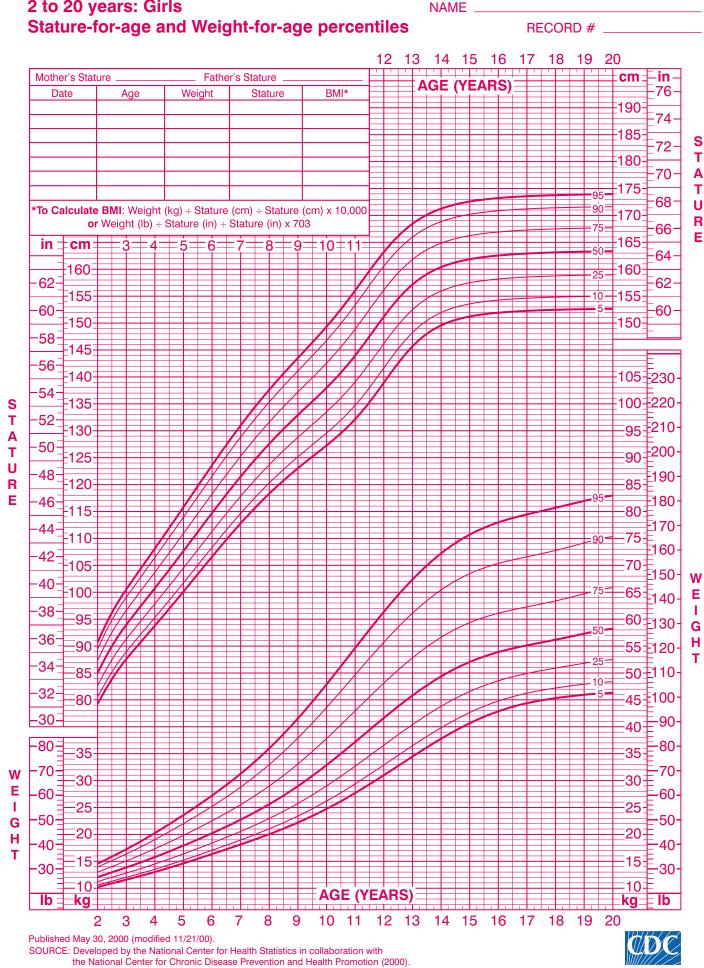
SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000). http://www.cdc.gov/growthcharts



2 to 20 years: Girls

http://www.cdc.gov/growthcharts

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SAFER · HEALTHIER · PEOPLE

Maryland Healthy Kids Program Medical/Family History Questionnaire

Patient Name:		Date of Birth: Sex: (circle) Male Female		
Form Completed By:	Today's Date	Relationship:		
PREGNANCY AND BIF		PSYCHOSOCIAL HISTORY		
Name of Hospital: Illnesses during pregnancy? Medications during pregnancy Alcohol/Drug Abuse? Problems at birth? Describe: Type of delivery?	No Yes ? No Yes No Yes No Yes No Yes I C-section charge Weight accine? No Yes on:	PSYCHOSOCIAL HISTORY Who lives in household? How many? □ Rent? Own? □ Rent? Own? □ Rent? Own? □ Date of Birth? Mother Father Father Are parents working? Mother No □ Foster Care? Other Languages?		
FAMILY HIST	ORY	MEDICAL HISTO	RY	
Has anyone in the family (parel aunts/uncles, sisters/brothers) Allergies (List) Asthma TB/Lung Disease HIV/AIDS Suicide Attempts Heart Disease High Blood Pressure/Stroke High Cholesterol Blood Disorders/Sickle Cell Diabetes Seizures Mental Illness Cancer Birth Defects Hearing Loss Speech Problems Kidney Disease Alcohol/Drug Abuse Hepatitis/Liver Disease Thyroid Disease Learning Problems/Attention Deficit Disorder Family Violence Other:	nts, grand-parents, had: Who? No Yes No Yes <	Has your child ever had: Allergies (List) Asthma Chicken Pox (Year) Frequent Ear Infections Vision/Hearing Problems Skin Problems/Eczema TB/Lung Disease Seizures/Epilepsy High Blood Pressure Heart Defects/Disease Liver Disease/Hepatitis Diabetes Kidney Disease/Bladder Infection Physical or Learning Disabilities Bleeding Disorders/Hemophilia Sexually Transmitted Diseases Emotional or Behavioral Problem Depression/Suicidal Thoughts Hospitalizations/Surgeries Physical/Emotional/ Sexual Abus Bone or Joint Injuries Obesity/Eating Disorders Other:	No Yes No Yes	
Reviewed by:		Date of Review:		

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Maryland Healthy Kids Program Cuestionario de Historial Médico Familiar

Nombre del Paciente:		Fecha de Nacimiento:	Sexo: M F (circule)		
Persona que llenó el Formulario:	Fecha de Hoy:	Relación con el Paciente::			
HISTORIAL DURANTE EMBA	RAZO Y AL NACER	HISTORIAL PSICOSOCIAL			
Nombre del Hospital: Enfermedades durante el emba Medicamentos durante embara Abuso de Alcohol o drogas Problemas al Nacer Describa: Tipo de Parto _ Vaginal [Peso al NacerPeso al dar El bebé recibió vacuna para He Fecha de la vacuna de Hepatitis Examen Auditivo para recien na	razo No Si zo No Si No Si No Si No Si Cesárea de alta patitis B No Si s B: acidos No Si C	¿Qué otro idiomas se hablan en	nogar? ☐ refugio No		
HISTORIAL FAN		HISTORIAL DE SALUD			
Asma TB/Enfermedad del Pulmón VIH/SIDA Intentos Suicidas/Problemas Mentales Enfermedad del Corazón Presión alta/Derrame Colesterol Alto Desórdenes de la Sangre/"Sickle Cell" Diabetes Convulsiones Alergias/Asma Desórdenes Mentales Cáncer Defectos de Nacimiento Pérdida de Audición Problemas de habla Enfermedades Renales Abuso de Alcohol/ Droga Hepatitis/Enfermedad del Hígado Enfermedad de la Tiroide Problemas de Aprendizaje/ Deficit de Atención ("ADD") Violencia Doméstica	¿Quién? No Si No Si	Alguna vez su niño/a ha tenido: Alergias (a qué) Asma Varicela (año) Infecciones frecuentes de oído Problemas de Audición/Infecciones de la Vista Problemas de la Piel/Eczema Asma/Alergias TB/Enfermedad del Pulmón Convulsiones/Epilepsia Hipertensión/Presión Alta Enfermedad del Corazón/Defectos Hepatitis/Enfermedad del Hígado Diabetes Enfermedades del Riñón/Vejiga Problemas Físicos o de Aprendizaje Desórdenes de la Sangre/Hemofilia Enfermedades Transmitidas Sexualmente Problemas Emocionales o de Comportamiento Depresión/Pensamientos Suicidas Hospitalizaciones/Cirugías Abuso /Físico/Emocional/ o Sexual Problemas en las Coyunturas/Huese Obesidad/Trastornos Alimenticios Otras: Lista de Medicamento/s que toma:	No Si I No Si I <td< td=""></td<>		
Revisado por:		Fecha que fue Revisado:			

OBJECTIVE HEARING AND VISION TESTING MARYLAND HEALTHY KIDS PROGRAM

Child's Name:	Date of Birth			
Objective Vision Testing recommended at	ages 3 to 6, 8, 10, 12, 15, and 18 years			
Date of Service:	Date of Service:			
Screened by:	Screened by:			
Ages 3 – 6	Ages 8 – 20			
Visual Acuity R L	Visual Acuity R L			
Muscle Balance: Near R L Far R L	Muscle Balance: Near R L Far R L			
Vision Fusion: Pass Fail	Hyperopia: Pass Fail			
Color Screens (optional): Pass Fail	Pass Fail			
Comments:	Comments:			
Objective Hearing Testing recommended a				
Date of Service:	Date of Service:			
Screened by:	Screened by:			
HZ 1000 2000 4000	HZ 1000 2000 4000			
Rtdb	Rtdb			
Ltdb	Ltdb			
Comments:	Comments:			