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.*

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