AmeriChoice AMERIGROUP Health Net Horizon NJ Health UHP other_____(08/04)

New Jersey: Early and Periodic Screening, Diagnosis and Treatment Exam

CHILDHOOD: 3 YEARS

DATE:

Child's Name:	Date of Birth:
Allergies:	Current Medications:
Illnesses/Accidents/Problems/Concerns since birth:	

Yes	No		Yes	No	
☐	☐	My child eats a variety of foods	☐	☐	My child can jump off a step with both feet
☐	☐	My child knows his or her own name, age and sex	☐	☐	My child is dry during the night most of the time
☐	☐	My family understands my child's speech	☐	☐	I have concerns about my child's hearing/vision

WEIGHT KG/LB PERCENTILE:	HEIGHT CM/FT/INS PERCENTILE:	BLOOD PRESSURE:

☐ Review of Systems ☐ Review of Family History

_____

_____

_____

_____

Screening	N	A	
Hearing	☐	☐	
Vision	☐	☐	_____
Development	☐	☐	_____
Behavior	☐	☐	_____
Social/Emotional	☐	☐	_____
Gross Motor	☐	☐	_____
Fine Motor	☐	☐	_____
Communication	☐	☐	_____

Physical	N	A		N	A
General Appearance	☐	☐	Lungs	☐	☐
Skin	☐	☐	Chest	☐	☐
Head	☐	☐	Cardiovascular/Pulses	☐	☐
Eyes	☐	☐	Abdomen	☐	☐
Ears	☐	☐	Genitalia	☐	☐
Nose	☐	☐	Spine	☐	☐
Oropharynx/Teeth	☐	☐	Extremities	☐	☐
Neck	☐	☐	Neurological	☐	☐
Nodes	☐	☐	Gait	☐	☐
Mental Health	☐	☐			

Describe findings:

_____

_____

_____

_____

_____

_____

Diet:_____

☐ Vitamin Supplement ☐ WIC Referral
☐ Fluoride Supplement ☐ Dental Referral
☐ Review Immunization Record ☐ Audiogram Referral
☐ TB Test (if high risk factors present) ☐ Hgb/Hct
☐ Cholesterol Screening (for high risk children) ☐ Urinalysis
☐ Lead Risk Assessment (verbal)

Elimination: _____

Sleep: _____

Other: _____

Health Education/Anticipatory Guidance:
(CHECK ALL COMPLETED)

☐ Nutrition ☐ Oral Health Care
☐ Development Benchmarks ☐ Child Care Issues
☐ Regular Physical Activities ☐ Discipline/Limits
☐ Car Seat or Booster Seat ☐ Friendship/Siblings
☐ Safety (general) ☐ Limit TV
☐ Lead Poisoning Prevention ☐ Toilet training
☐ Passive Smoke

Other: _____

Assessment:

_____

_____

_____

Diagnosis:

_____

Treatment Plan:

_____

_____

_____

REFERRALS:

_____

_____

_____

IMMUNIZATIONS: ☐ given (see VFC Form) ☐ up to date

NEXT VISIT: 4 YEARS OF AGE

Health Provider Signature: