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

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

CHILDHOOD: 6 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 seems rested when he/she awakens
☐	☐	My child can play make believe	☐	☐	My child knows right from left
☐	☐	My child can count	☐	☐	My child gets some physical activity every day

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

Diet:____

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

☐ Review of Systems ☐ Review of Family History

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Elimination: ________________________________
Sleep: ________________________________
Other: ________________________________

Screening

	N	A	
Hearing	☐	☐	____________
Vision	☐	☐	____________
Development	☐	☐	____________
Behavior	☐	☐	____________
Social/Emotional	☐	☐	____________

Health Education/Anticipatory Guidance:
(CHECK ALL COMPLETED)

☐ Nutrition ☐ Oral Health Care
☐ Development Benchmarks ☐ Child Care Issues
☐ Regular Physical Activities ☐ Discipline/Limits
☐ Car Booster Seat or Seatbelt ☐ School Issues
☐ Safety (general) ☐ Limit TV
☐ Adequate Sleep/Habits ☐ Helmets
☐ Passive Smoke

Other: ________________________________

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	☐	☐			

Assessment:

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Describe findings:

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Diagnosis:

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Treatment Plan:

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REFERRAL:

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

NEXT VISIT: 7 YEARS OF AGE

Health Provider Signature: