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

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

CHILDHOOD: 8 YEARS

DATE:

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

Yes	No		Yes	No	
☐	☐	My child eats breakfast every day	☐	☐	My child seems rested when he/she awakens
☐	☐	My child is doing well in school	☐	☐	My child handles stress, anger, and frustration appropriately
☐	☐	My child has one or more close friends	☐	☐	My child gets some physical activity every day

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

☐ Review of Systems ☐ Review of Family History

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

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:

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Diet:____

☐ Dental Referral
☐ Fluoride Supplement
☐ Vitamin Supplement
☐ TB Test (if high risk factors present)
☐ Cholesterol Screening (for high risk children)
☐ Review Immunization Record

Elimination: ____

Sleep: ____

Other: ____

Health Education/Anticipatory Guidance:
(CHECK ALL COMPLETED)

☐ Nutrition	☐ Oral Health Care
☐ Development	☐ Parenting Issues
☐ Regular Physical Activities	☐ Child Care Issues
☐ Seat Belt	☐ Adequate Sleep
☐ Safety (general)	☐ Helmets
☐ Passive Smoke	☐ School Issues
☐ Limit TV	

Other: ____

Assessment:

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Diagnosis:

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Treatment Plan:

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REFERRALS:

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

NEXT VISIT: 9 YEARS OF AGE

Health Provider Signature: