### PHYSICAL EXAMINATION

**(check appropriate box):**

<table>
<thead>
<tr>
<th>General</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Fontanels</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyes: Red Reflex, Appearance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ears, TMs</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Nose</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Lips/Palate</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Teeth/Gums</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Tongue/Pharynx</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Neck/Nodes</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Chest/Breast</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Lungs</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Heart</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Abd/Umbilicus</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Genitalia/ Femoral Pulses</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Extremities, Clavicles, Hips</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Muscular</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Neuromotor</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Back/Sacral Dimple</td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>

**SENSORY SCREENING:**

Any parent concerns about vision or hearing?  ❑ Yes  ❑ No

**Vision:** (at least 1 acuity/alignment exam required between 3 and 5 yrs)

Acuity (Allen cards, Snellen chart, or HOTV test) done  ❑ Yes  ❑ No

**Hearing:**

Passed Screen  ❑ Right  ❑ Left  ❑ Bilaterally

Failed Screen  ❑ Right  ❑ Left  ❑ Bilaterally

Refered for: Audiological evaluations  ❑ Conditioned play audiometry or  ❑ OAEs

**ACUTE HISTORY:**

**HISTORY:**

**Parent Concerns:**

__________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

**Initial/Interval History:**

__________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

**SENSORY SCREENING:**

Any parent concerns about vision or hearing?  ❑ Yes  ❑ No

**Vision:** (at least 1 acuity/alignment exam required between 3 and 5 yrs)

Acuity (Allen cards, Snellen chart, or HOTV test) done  ❑ Yes  ❑ No

**Hearing:**

Passed Screen  ❑ Right  ❑ Left  ❑ Bilaterally

Failed Screen  ❑ Right  ❑ Left  ❑ Bilaterally

Refered for: Audiological evaluations  ❑ Conditioned play audiometry or  ❑ OAEs

**PHYSICAL EXAMINATION (check appropriate box):**

<table>
<thead>
<tr>
<th>N</th>
<th>L</th>
<th>A</th>
<th>B</th>
<th>E</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>NL</td>
<td>AB</td>
<td>NE</td>
<td>NL-normal, AB-abnormal, NE-not examined</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**DEVELOPMENTAL/BEHAVIORAL ASSESSMENT:**

Parent Concerns Discussed? (Required)  ❑ Yes

Standardized Screen Used? (Suggested by AAP)  ❑ Yes  ❑ No

See instrument form: ❑ PEDS  ❑ Ages & Stages

❑ Other: ____________________________

DB Concerns: (e.g. sleep/feeding) ____________________________

Clinician Concerns regarding interaction:

<table>
<thead>
<tr>
<th>Motor Skills (observe head, trunk, and limb control)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hops on one foot; walks in a line</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Fine Motor Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Needs no help with eating; can use knife to butter</td>
</tr>
<tr>
<td>Can brush teeth, wash hands, get a drink</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Language/Socioemotional/Cognitive Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uses 3-5 word sentences; uses plurals (cats/dogs)</td>
</tr>
<tr>
<td>Asks &quot;who&quot;, &quot;what&quot;, &quot;where&quot;, and &quot;when&quot; questions</td>
</tr>
<tr>
<td>Understands &quot;now&quot;, &quot;soon&quot;, and &quot;later&quot;</td>
</tr>
<tr>
<td>3-minute attention span; minimal understanding of yesterday and tomorrow</td>
</tr>
<tr>
<td>Identifies some colors; draws easy shapes</td>
</tr>
<tr>
<td>Uses bathroom with some help</td>
</tr>
<tr>
<td>Can almost dress himself</td>
</tr>
<tr>
<td>Likes to be with other children but still doesn't cooperate or share well</td>
</tr>
</tbody>
</table>

**Parent – Infant Interaction**

Interaction appears age appropriate  | Y | N |

Clinician Concerns regarding interaction:

**Clinical Observations/History: (Suggested options)**
(EPSDT) 3 - Year Visit Page 2

NAME: ___________________________ DOB: ____________
MED RECORD #: ___________________________ DOV: ________

ANTICIPATORY GUIDANCE:
Select at least one topic in each category (as appropriate to family):

Injury/Serious Illness Prevention:
- Car Seat
- Falls
- Burns-hot water heater max temp 125 degrees F
- Smoke alarms
- No passive smoke (Oklahoma Tobacco Helpline: 1.800.QUIT.NOW)
- Sun protection
- Water safety
- Other: ____________________________________________

Violence Prevention:
- Adequate support system?
- Adequate respite?
- Feel safe in neighborhood?
- Domestic Violence?
- Gun Safety
- Other: ____________________________________________

Sleep Safety Counseling:
- Sleep Interaction
- Read to child (e.g. Reach out and Read)
- Limit TV (day and nighttime)
- Other: ____________________________________________

Nutrition Counseling:
- Begin 2% cow’s milk (~16 oz/day)
- Limit juice (4 oz or less/day)
- Whole grains
- Healthy snacks
- Vitamins
- No popcorn, peanuts, hard candy
- Other: ____________________________________________

What to anticipate before next visit:
- Child-proofing
- Discipline
- Help child learn self-control skills (e.g., not interrupting, not fighting with siblings)
- Different rates of development are normal
- Establishes routines
- Offer clear and simple choices
- Other: ____________________________________________

PROCEDURES:
- Hematocrit of Hemoglobin
- TB Test
- Cholesterol Screening
- Blood lead test

DENTAL REMINDER
- Yearly dental referral
- Fluoride source?

IMMUNIZATIONS DUE at this visit:
Flu (yearly)
- Given
- Not Given
- Up to Date
Date Flu previously given: ______________

Catch-up on vaccines:
- #
- Given
- Not Given
- Up to Date

Reason Not Given if due: List Vaccine(s) not given:
- Vaccine not available
- Child ill
- Parent Declined
- Other

PLAN/RECOMMENDATIONS:
- Do vaccines/procedures marked above
- Other: ____________________________________________
- See box above for Anticipatory Guidance Topics discussed at today’s visit

ASSESSMENT:
- Healthy, no problems

PLAN/RECOMMENDATIONS:

Next Health Supervision (EPSDT) Visit Due: ______________

Provider Signature: ___________________________ Date: ____________________________

OHCA Revised 03/13/2014