**General**

Skin

**HISTORY:**

Parent Concerns:

______________________________________________

______________________________________________

______________________________________________

______________________________________________

Maternal & Birth History:

- Birth HX form reviewed
- Initial/Interval History:

FSH:

- FSH form reviewed (check other topics discussed):
  - Daily care provided by
  - Adequate support system? Yes No
  - Adequate respite? Yes No

DEVELOPMENTAL/BEHAVIORAL ASSESSMENT:

Parent Concerns Discussed? (Required)

- Yes

Standardized Screen Used? (Optional)

- Yes

See instrument form:

- PEDS
- Ages & Stages

DB Concerns:

(e.g. crying/colic)

Clinician Observations/History: (Suggested options)

**Motor skills** (observe head, trunk and limb control)

- Visually tracks objects to midline
- Moves arms and legs equally
- Arms and legs are usually flexed
- Full head lag in pull to sit from supine
- Raises head slightly off table in prone
- Moro, root, grasp, suck present
- Face symmetric with cry

**Fine Motor skills**

- Hands are usually fisted
- Grasps objects reflexively

**Language/Socioemotional skills**

- Vocalizes/Coos
- Startles at loud noise

**Parent - Infant Interaction** (maternal depression present in 50% of post-partum mothers):

- Interaction appears age appropriate

Clinician concerns re interaction:

**SENSORY SCREENING:**

Any parent concerns about vision or hearing? Yes No

**Vision:**

- Blinks in reaction to bright light: Yes No

**Hearing:**

- Passed NBHS (B): Yes Not Given U/K Failed NBHS
- Responds to sounds: Yes No Left Right

**PHYSICAL EXAMINATION** (check box):

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

Skin

Fontanels

Eyes: Red Reflex, Appearance

Ears, TMs

Nose

Lips/Palate

Teeth/Gums

Tongue/Pharynx

Neck/Nodes

Chest/Breast

Lungs

Heart

Abd/Umbilicus

Genitalia/ Femoral Pulses

Extremities, Clavicles, Hips

Muscular

Neuromotor

Back/Sacral dimple

Clinician concerns re interaction:
(EPSDT) 1-Week Visit Page 2

NAME: ____________________ DOB: ____________
MED RECORD #: _____________________

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

**Injury/Serious Illness Prevention:**
- Car Seat
- Falls
- No strings around neck
- No shaking
- Burns-hot water heater max temp 125 degrees F
- Smoke alarms
- No passive smoke (Oklahoma Tobacco Helpline: 1.800.QUIT.NOW)
- No sun exposure
- Fever management
- Other: _______________________

**Violence Prevention:**
- Adequate support system?
- Adequate respite?
- Feel safe in neighborhood?
- Domestic Violence?
- No Shaking
- Other: _______________________

**Sleep Positioning Counseling:**
- Sleep (on back)
- Sleep Safety
- Normal for newborns to sleep most of the day and night
- Other: _______________________

**Nutrition Counseling:**
- Breast
- Formula
- Solids (4-6mo)
- 3-4 hour between feeding
- Less frequent stools typical for bottle fed infants
- 5-8 wet diapers/day
- Vitamins/Fluoride
- No honey
- No bottle prop
- No microwave
- Other: _______________________

**PROCEDURES:**
- Hereditary/Metabolic Screening needed
- Hereditary/Metabolic Screening results reviewed – Normal
- Hereditary/Metabolic Screening results reviewed – Other:

**IMMUNIZATIONS DUE at this visit:**

**HepB #**
- Given
- Not Given
- Up to Date

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

**What to anticipate before next visit:**
- More awake time
- Sleep cycle gets more regular
- Change in feeding/stooling patterns
- Other: _______________________

**Assessment:**
- Healthy, no problems

**Plan/Recommendations:**
- Do vaccines/procedures marked above
- Anticipatory guidance discussed (as described in box above)

**Next Health Supervision (EPSDT) Visit Due:**

Provider Signature: ___________________________ Date: ________________________