**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 ☐ Daycare ☐ Parent

☐ Other:

Adequate support system? ☐ Yes ☐ No

Adequate respite? ☐ Yes ☐ No

**DEVELOPMENTAL/BEHAVIORAL ASSESSMENT:**

Parent Concerns Discussed? (Required) ☐ Yes

Standardized Screen Used? (Optional) ☐ Yes ☐ No

See instrument form: ☐ PEDS ☐ Ages & Stages

☐ Other: __________

DB Concerns: (e.g. crying/colic) ____________________

________________________________________________

**Clinician Observations/History: (Suggested options)**

<table>
<thead>
<tr>
<th>Motor Skills (observe head, trunk, and limb control)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visually tracks objects beyond midline</td>
</tr>
<tr>
<td>Moves arms and legs equally</td>
</tr>
<tr>
<td>Rolls over both ways</td>
</tr>
<tr>
<td>ATNR (fencer position) gone</td>
</tr>
<tr>
<td>Sits alone</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Fine Motor Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reaches for and rakes at objects</td>
</tr>
<tr>
<td>Transfers objects hand to hand (by 5 mos)</td>
</tr>
<tr>
<td>Regards small wad of paper</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Language/Socioemotional Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Babbles (vowel-consonant)</td>
</tr>
<tr>
<td>Raspberry noises (by 5 mos)</td>
</tr>
<tr>
<td>Says ah-goo (by 5 mos)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Parent – Infant Interaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interaction appears age appropriate</td>
</tr>
</tbody>
</table>

Clinician concerns regarding interaction:

**SENSORY SCREENING:**

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

Vision:

Follows objects and eyes team together: ☐ Yes ☐ No

Hearing:

Responds to sounds: ☐ Yes ☐ No

**PHYSICAL EXAMINATION (check box):**

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

- 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 Observations/History: (Suggested options)

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(EPSDT) 6 - Month 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 ☐ 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:
☐ Other: ____________________________________________

Sleep Safety Counseling:
☐ Sleep Safety
☐ Other: ____________________________________________

Nutrition Counseling:
☐ Breast ☐ Formula ☐ Solids ☐ Less frequent stools typical for bottle fed infants ☐ 5-8 wet diapers/day ☐ Vitamins ☐ No honey ☐ No bottle prop ☐ No microwave ☐ No infant feeders
☐ Other: ____________________________________________

What to anticipate before next visit:
☐ Sleep cycle may get disturbed when stranger anxiety begins (around 9 mos) ☐ Change in feeding/stooling patterns ☐ Pulling up to cruise holding on to furniture by 9 mos ☐ Okay to allow infant to finger feed ☐ Back to work? ☐ Weaning? ☐ Temperament style ☐ Walkers ☐ Childproofing ☐ Discipline ☐ Different rates of development are normal ☐ Other: ____________________________________________

ASSESSMENT: ☐ Healthy, no problems
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

PLAN/RECOMMENDATIONS: ☐ Do vaccines/procedures marked above ☐ Other ____________________________________________
☐ Anticipatory guidance discussed (as described in box above)
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Next Health Supervision (EPSDT) Visit Due: __________________________

Provider Signature: ___________________________ Date: ____________________________

DENTAL REMINDER
PCP screen 1st tooth eruption
Fluoride (check on type of water and public water supply content)

IMMUNIZATIONS DUE at this visit:
☐ Information provided and consent for each on given
HepB3 (if needed) # ________
☐ Given ☐ Not Given ☐ Up to Date
DTap3 # ________
☐ Given ☐ Not Given ☐ Up to Date
Hib3 # ________
☐ Given ☐ Not Given ☐ Up to Date
IPV3 # ________
☐ Given ☐ Not Given ☐ Up to Date
PCV3 # ________
☐ Given ☐ Not Given ☐ Up to Date
Rotavirus2 # ________
☐ Given ☐ Not Given ☐ Up to Date
Flu (yearly)
☐ Given ☐ Not Given ☐ Up to Date

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

PROCEDURES:

PROCEDES:

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