

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

## INFANCY: 15 MONTHS

DATE:

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

  

<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>	
<input type="checkbox"/>	<input type="checkbox"/>	My child feeds self with fingers	<input type="checkbox"/>	<input type="checkbox"/>	My child walks well, stoops and climbs stairs
<input type="checkbox"/>	<input type="checkbox"/>	My child can say 3 to 6 words	<input type="checkbox"/>	<input type="checkbox"/>	My child understands simple commands

  

WEIGHT KG/LB PERCENTILE:	HEIGHT CM/IN PERCENTILE:	HEAD CIR. PERCENTILE:	Diet: _____
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<input type="checkbox"/> Review of Systems <input type="checkbox"/> Review of Family History     				<input type="checkbox"/> Vitamin Drops with Iron <input type="checkbox"/> Dental Referral <input type="checkbox"/> Fluoride Supplements <input type="checkbox"/> WIC Referral <input type="checkbox"/> Review Immunization Record <input type="checkbox"/> Hgb/Hct <input type="checkbox"/> TB Test (if high risk factors present) <input type="checkbox"/> Lead Risk Assessment (verbal)			
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<b>Screening</b> <b>N</b> <b>A</b> Hearing <input type="checkbox"/> <input type="checkbox"/> _____ Vision <input type="checkbox"/> <input type="checkbox"/> _____ Development <input type="checkbox"/> <input type="checkbox"/> _____ Behavior <input type="checkbox"/> <input type="checkbox"/> _____ Social/Emotional <input type="checkbox"/> <input type="checkbox"/> _____ Gross Motor <input type="checkbox"/> <input type="checkbox"/> _____ Fine Motor <input type="checkbox"/> <input type="checkbox"/> _____				<b>Elimination:</b> _____ <b>Sleep:</b> _____ <b>Other:</b> _____			
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<b>Physical</b> <b>N</b> <b>A</b> <b>N</b> <b>A</b> General Appearance <input type="checkbox"/> <input type="checkbox"/> Lungs <input type="checkbox"/> <input type="checkbox"/> Skin <input type="checkbox"/> <input type="checkbox"/> Chest <input type="checkbox"/> <input type="checkbox"/> Head/Fontanelle <input type="checkbox"/> <input type="checkbox"/> Cardiovascular/Pulses <input type="checkbox"/> <input type="checkbox"/> Eyes <input type="checkbox"/> <input type="checkbox"/> Abdomen <input type="checkbox"/> <input type="checkbox"/> Ears <input type="checkbox"/> <input type="checkbox"/> Genitalia <input type="checkbox"/> <input type="checkbox"/> Nose <input type="checkbox"/> <input type="checkbox"/> Spine <input type="checkbox"/> <input type="checkbox"/> Oropharynx/Teeth <input type="checkbox"/> <input type="checkbox"/> Extremities <input type="checkbox"/> <input type="checkbox"/> Mental Health <input type="checkbox"/> <input type="checkbox"/> Neurological <input type="checkbox"/> <input type="checkbox"/>				<b>Health Education/Anticipatory Guidance:</b> <b>(CHECK ALL COMPLETED)</b> <input type="checkbox"/> Nutrition/Feeding <input type="checkbox"/> Toilet Training <input type="checkbox"/> Weaning <input type="checkbox"/> Passive Smoke <input type="checkbox"/> Car seat or Booster Seat <input type="checkbox"/> Language Development <input type="checkbox"/> Development Benchmarks <input type="checkbox"/> Discipline/Limits <input type="checkbox"/> Safety (general) <input type="checkbox"/> Oral Health Care <input type="checkbox"/> Lead Poisoning Prevention <input type="checkbox"/> Crib Mattress Lowered <input type="checkbox"/> Discipline/Limits <input type="checkbox"/> Child Care Issues  <b>Other:</b> _____			
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<b>Describe findings:</b>         				<b>Assessment:</b>    			
				<b>Diagnosis:</b>   			
				<b>Treatment Plan:</b>    			
				<b>REFERRALS:</b>     			
				<b>IMMUNIZATIONS:</b> <input type="checkbox"/> given (see VFC Form) <input type="checkbox"/> up to date			

**NEXT VISIT: 18 MONTHS OF AGE**

Health Provider Signature: