

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

CHILDHOOD: 18 MONTHS

DATE: _____

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

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	My child feeds self	<input type="checkbox"/>	<input type="checkbox"/>	My child waves "bye bye"
<input type="checkbox"/>	<input type="checkbox"/>	My child can say 6 – 12 words	<input type="checkbox"/>	<input type="checkbox"/>	My child can follow simple directions

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"/> TB Test (if high risk factors present) <input type="checkbox"/> Lead Risk Assessment (verbal)			
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Screening	N	A	
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"/>	_____

Physical	N	A		N	A	
General Appearance	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Lungs
Skin	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Chest
Head/Fontanelle	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular/Pulses
Eyes	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Abdomen
Ears	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Genitalia
Nose	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Spine
Oropharynx/Teeth	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Extremities
Mental Health	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Neurological

Describe findings: _____ _____ _____ _____ _____ _____	Elimination: _____ Sleep: _____ Other: _____ Health Education/Anticipatory Guidance: (CHECK ALL COMPLETED) <input type="checkbox"/> Nutrition <input type="checkbox"/> Toilet Training <input type="checkbox"/> Safety (general) <input type="checkbox"/> Passive Smoke <input type="checkbox"/> Car Seat or Booster Seat <input type="checkbox"/> Oral Health Care <input type="checkbox"/> Development Benchmarks <input type="checkbox"/> Discipline/Limits <input type="checkbox"/> Language Development <input type="checkbox"/> Lead Poisoning Prevention <input type="checkbox"/> Bath Safety <input type="checkbox"/> Supervision <input type="checkbox"/> Child Care Issues Other: _____ Assessment: _____ _____ Diagnosis: _____ Treatment Plan: _____ _____ REFERRALS: _____ _____ IMMUNIZATIONS: <input type="checkbox"/> given (see VFC Form) <input type="checkbox"/> up to date
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NEXT VISIT: 24 MONTHS OF AGE

Health Provider Signature: _____