

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

## CHILDHOOD: 3 YEARS

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 eats a variety of foods	<input type="checkbox"/>	<input type="checkbox"/>	My child can jump off a step with both feet
<input type="checkbox"/>	<input type="checkbox"/>	My child knows his or her own name, age and sex	<input type="checkbox"/>	<input type="checkbox"/>	My child is dry during the night most of the time
<input type="checkbox"/>	<input type="checkbox"/>	My family understands my child's speech	<input type="checkbox"/>	<input type="checkbox"/>	I have concerns about my child's hearing/vision

  

WEIGHT KG/LB PERCENTILE:	HEIGHT CM/FT/INS PERCENTILE:	BLOOD PRESSURE:	Diet: _____
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<input type="checkbox"/> Review of Systems <input type="checkbox"/> Review of Family History  <hr/> <hr/> <hr/> <hr/> <table border="0" style="width: 100%;"> <tr> <td style="width: 15%;"><b>Screening</b></td> <td style="width: 10%;"><b>N</b></td> <td style="width: 10%;"><b>A</b></td> <td style="width: 65%;"></td> </tr> <tr><td>Hearing</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td></td></tr> <tr><td>Vision</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td></td></tr> <tr><td>Development</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td></td></tr> <tr><td>Behavior</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td></td></tr> <tr><td>Social/Emotional</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td></td></tr> <tr><td>Gross Motor</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td></td></tr> <tr><td>Fine Motor</td><td><input 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type="checkbox"/> Nutrition  <input type="checkbox"/> Development Benchmarks  <input type="checkbox"/> Regular Physical Activities  <input type="checkbox"/> Car Seat or Booster Seat  <input type="checkbox"/> Safety (general)  <input type="checkbox"/> Lead Poisoning Prevention  <input type="checkbox"/> Passive Smoke </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Oral Health Care  <input type="checkbox"/> Child Care Issues  <input type="checkbox"/> Discipline/Limits  <input type="checkbox"/> Friendship/Siblings  <input type="checkbox"/> Limit TV  <input type="checkbox"/> Toilet training </td> </tr> </table> Other: _____  <b>Assessment:</b> <hr/> <hr/> <hr/> <b>Diagnosis:</b> <hr/> <hr/> <hr/> <b>Treatment Plan:</b> <hr/> <hr/> <hr/> <hr/> <b>REFERRALS:</b> <hr/> <hr/> <hr/> <hr/> <b>IMMUNIZATIONS:</b> <input type="checkbox"/> given (see VFC Form) <input type="checkbox"/> up to date	<input type="checkbox"/> Nutrition <input type="checkbox"/> Development 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**NEXT VISIT: 4 YEARS OF AGE**

Health Provider Signature: