AmeriChoice AMERIGROUP Health Net Horizon NJ Health UHP other_____(08/04)

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

CHILDHOOD: 7 YEARS

DATE:

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

Yes	No		Yes	No	
☐	☐	My child eats a variety of foods	☐	☐	My child seems rested when he/she awakens
☐	☐	My child plays well with other kids	☐	☐	My child knows right from left
☐	☐	My child can count	☐	☐	My child gets some physical activity every day

WEIGHT KG/LB PERCENTILE:	HEIGHT CM/FT/INS PERCENTILE:	BLOOD PRESSURE:

☐ Review of Systems ☐ Review of Family History

_____

_____

_____

_____

Screening	N	A	
Hearing	☐	☐	_____
Vision	☐	☐	_____
Development	☐	☐	_____
Behavior	☐	☐	_____
Social/Emotional	☐	☐	_____

Physical	N	A		N	A
General Appearance	☐	☐	Lungs	☐	☐
Skin	☐	☐	Chest	☐	☐
Head	☐	☐	Cardiovascular/Pulses	☐	☐
Eyes	☐	☐	Abdomen	☐	☐
Ears	☐	☐	Genitalia	☐	☐
Nose	☐	☐	Spine	☐	☐
Oropharynx/Teeth	☐	☐	Extremities	☐	☐
Neck	☐	☐	Neurological	☐	☐
Nodes	☐	☐	Gait	☐	☐
Mental Health	☐	☐			

Describe findings:

_____

_____

_____

_____

_____

_____

_____

_____

Diet:_____

☐ Vitamin Supplement
☐ Fluoride Supplement
☐ Review Immunization Record
☐ TB Test (if high risk factors present)
☐ Cholesterol Screening (for high risk children)
☐ Dental Referral

Elimination: _____

Sleep: _____

Other: _____

Health Education/Anticipatory Guidance:
(CHECK ALL COMPLETED)

☐ Nutrition	☐ Oral Health Care
☐ Development	☐ Parenting Issues
☐ Regular Physical Activities	☐ Discipline/Limits
☐ Booster or Seat Belt	☐ School Issues
☐ Safety (general)	☐ Child Care Issues
☐ Matches, Poisons, Guns	☐ Helmets
☐ Passive Smoke	☐ Adequate Sleep/habits
☐ Violence Prevention	☐ Injury Prevention
☐ Limit TV	

Other: _____

Assessment:

_____

_____

_____

Diagnosis:

_____

Treatment Plan:

_____

_____

_____

REFERRALS:

_____

_____

_____

IMMUNIZATIONS: ☐ given (see VFC Form) ☐ up to date

NEXT VISIT: 8 YEARS OF AGE

Health Provider Signature: