EPSDT-Iowa Child Health and Development Record — 0-4 Week Well Exam

Name				Accompanied by
Date	MRN	Date of Birth	Sex ❍ M ❍ F	Preferred Language

ATTACH LABEL

CAREGIVER CONCERNS/INTERVAL HISTORY ❑ None

PAST MEDICAL HISTORY ❑ Reviewed and updated
SURGICAL HISTORY ❑ Reviewed and updated
FAMILY HISTORY ❑ Reviewed and updated

MEDICATIONS ❑ None ❑ Reviewed and updated
ALLERGIES ❑ No known drug allergies
❑ _____

Nutrition:
❑ Breast feeding: _____times/day
❑ Pumped breast milk _____oz/day
❑ Formula _____oz/day
❑ Vitamin D (When breastfeeding)
❑ Multivitamin with iron (for premature infants)

Water Source: ❑ City tap ❑ Filtered/bottled
❑ Well: regularly tested? ❍ Yes ❍ No

Elimination: Stools: _____per day
Wet diapers per day _____

Sleep: Longest sleep stretch through the night ____ hrs

YES	NO	
❍	❍	Safe sleep environment _____
❍	❍	Back to sleep _____
❍	❍	Bed sharing _____

Newborn Screening:
Metabolic ❍ Normal ❍ Abnormal
Hearing ❍ Pass ❍ Refer/Fail
Critical congenital heart disease ❍ Pass ❍ Fail

RISK ASSESSMENT

HIGH	LOW	
❍	❍	Vision Concerns _____
❍	❍	Hearing Concerns _____
❍	❍	TB Risk _____

DEVELOPMENT: Screen or refer if concerns

YES	NO	
❍	❍	Focuses on faces
❍	❍	Responds to sound
❍	❍	Lifts head briefly when prone
❍	❍	Moves arms and legs equally

Caregiver concerns about development:

SOCIAL HISTORY: ❑ Reviewed and updated

Lives with: ☐ 1 parent ☐ 2 parents ☐ Other caregiver

☐ Others (including siblings):

FAMILY RISK FACTORS:

Changes in family since last visit:

Caregiver job status:

Do you need additional assistance with any of the following?

☐ Getting enough to eat ☐ Relationships ☐ Drug abuse
☐ Violence/Abuse ☐ Financial ☐ Alcohol abuse
☐ Health Insurance ☐ Child care
☐ Other _____

Maternal/Caregiver PHQ2 Depression Screening:
Over the last 2 weeks, how often have you been bothered by any of the following problems?

0-Not at all 1-Several days
2-More than half the days 3-Nearly every day

Little interest or pleasure in doing things 0☐ 1☐ 2☐ 3☐
Feeling down, depressed, or hopeless 0☐ 1☐ 2☐ 3☐
Total score _____

For scores 3 or over please complete PHQ9

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PHYSICAL EXAMINATION

Length_____cm (_____%ile)		Weight_____Kg (_____%ile)		Head circumference _____cm (_____%ile)	
VITALS:	Temp: _____	BP (if high risk) ____/____(___%ile ___%ile)	HR: _____	Resp Rate: _____	SpO_2 _____

Normal examinination findings are listed below. Describe other findings in the area provided.

General: Well appearing, active, and alert. _____

Head: Normocephalic and atraumatic. Anterior fontanelle open and flat. _____

Eyes: Red reflex, present bilaterally. Pupils equal, round, and reactive to light. No discharge._____

ENT: No ear deformities. Normal external canals. Tympanic membranes clear bilaterally. Nares patent. _____

Mouth: No oral lesions or thrush. _____

Neck: Supple, with full range of motion. _____

Cardiovascular: Regular rate and rhythm. Heart sounds S1, S2 normal. No murmur. _____

Chest: No increased work of breathing. Clear and symmetric breath sounds bilaterally. _____

Abdomen: Soft, non-distended, no masses, no hepatosplenomegaly. _____

Genitourinary: _____

- ❑ Normal female external genitalia. _____
- ❑ Normal male external genitalia. Testes descended bilaterally, no scrotal swelling, no inguinal hernia. _____

Musculoskeletal: Spine normal. Negative Ortolani and Barlow maneuvers. Moves all extremities symmetrically.

_____

Neurological: Normal strength and tone. _____

Skin: Normal color. No lesions. _____

- ❑ Birthmarks (if applicable) _____

Other comments:

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ANTICIPATORY GUIDANCE:

FAMILY WELL-BEING:
- ❑ Self-care for caregivers
- ❑ Post-partum checkup
- ❑ Maternal depression
- ❑ Sibling adjustment to infant
- ❑ Family support
- ❑ Plan for return to work
- ❑ Food security
- ❑ Resources for local child care

FAMILY NUTRITION/ORAL HEALTH:
- ❑ Safe pumping & storage of breast milk
- ❑ Introduce bottle by 1 month if going to daycare
- ❑ No bottle propping

BEHAVIOR:
- ❑ Importance of talking, reading, singing, cuddling
- ❑ Learn baby's responses, temperament

SAFETY:
- ❑ Sleep environment—firm mattress, no loose bedding, crib slats < 2 ⅜" apart
- ❑ Encourage day/night routine and supervised tummy time
- ❑ Safe sleep practices
- ❑ Water heater set below 120°
- ❑ If smoking in home: discuss quitting, limiting exposure
- ❑ Rear-facing car seat
- ❑ Always one hand on baby (never leave on changing table, couch, bed)
- ❑ Wash hands before feeding and after diaper changes
- ❑ Pertussis vaccine for adults in household
- ❑ Influenza and Covid-19 vaccine for household contacts

ASSESSMENT

Well Child Exam
- ❑ Normal findings (normal interval growth, age appropriate development)
- ❑ Abnormal findings _____

_____

_____

PLAN OF CARE (see Anticipatory Guidance)

Immunizations:
- ❑ Vaccine Information Statements given
- ❑ Vaccine counseling given
- ❑ Vaccines due: ❑ HepB (if not given at birth)

Past adverse reactions to immunizations:
❑ No ❑ Yes_____

See current guidelines: https://www.cdc.gov/vaccines/index.html

LAB:
- ❑ Bili (if indicated)
- ❑ Hip ultrasound at 6 weeks (if indicated)
- ❑ Other _____

Developmental Follow-up:
❑ No delays ❑ Follow-up in office ❑ Referral

Referral: (if indicated) ❑ Vision ❑ TB risk assessment

1st Five Healthy Mental Development Initiative: In available counties, contact 1st Five for developmental concerns or needs assessment at idph.iowa.gov/1stfive

Early ACCESS Line: For referral of children birth to age 3 with developmental delay to local Early Access providers, call (888) 425-4371 or go to: iafamilysupportnetwork.org

Healthy Families Line: For assistance with care coordination, transportation, or health information for children birth through age 21 call (800) 369-2229

Return appointment:
- ❑ Follow-up _____(days/weeks/months)
- ❑ Follow-up hearing screen if at risk _____
- ❑ Other/referral based on risk assessment _____

_____

_____

_____

Signature _____ Date _____

ATTACH LABEL

NOTES

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