EPSDT-Iowa Child Health and Development Record

2 Month 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:

YES	NO	
❍	❍	Soft, easy to pass BMs ________________
❍	❍	Issues with constipation ________________
❍	❍	Normal urine stream ________________

Sleep: Longest sleep stretch through the night ____ hrs

YES	NO	
❍	❍	Safe sleep environment ________________
❍	❍	Put to bed awake at night and naps ______
❍	❍	Back to sleep ________________
❍	❍	Bottle in bed ________________

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

RISK ASSESSMENT

HIGH	LOW	
❍	❍	Vision Concerns ________________
❍	❍	Hearing Concerns ________________

DEVELOPMENT: **Screen or refer if concerns**

YES	NO	
❍	❍	Looks at your face
❍	❍	Smiles when you talk to or smile at her
❍	❍	Makes sounds other than crying
❍	❍	Reacts to loud sounds
❍	❍	Watches you as you move
❍	❍	Looks at a toy for several seconds
❍	❍	Holds head up when on tummy
❍	❍	Moves both arms and both legs

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.

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Neurological: Normal strength and tone. ____________________

Skin: Normal color. No lesions. ____________________

- ❑ Birthmarks (if applicable) ____________________

Other comments:

ATTACH LABEL

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ANTICIPATORY GUIDANCE:

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

FAMILY NUTRITION/ORAL HEALTH:
- ❑ Safe pumping & storage of breast milk
- ❑ Wait to introduce solids until around 6 months of age
- ❑ No honey until 1 year
- ❑ 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 ³⁄₈" apart
- ❑ Encourage day/night routine and supervised tummy time
- ❑ Safe sleep practices
- ❑ No swaddling after 2 months
- ❑ Water heater set below 120°
- ❑ If smoking in home: discuss quitting, limiting exposure
- ❑ Rear-facing car seat
- ❑ Baby may roll - 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 ______________________________

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PLAN OF CARE (see Anticipatory Guidance)

Immunizations:
- ❑ Vaccine Information Statements given
- ❑ Vaccine counseling given
- ❑ Vaccines due:
  - ❑ HepB
  - ❑ DTaP
  - ❑ Rotavirus
  - ❑ Hib
  - ❑ PCV13
  - ❑ IPV

❑ Catch-up vaccinations given ______________

High risk: ❑ MenACWY-CRM (Menveo) ≥2 mos

Past adverse reactions to immunizations:

❑ No ❑ Yes ______________

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

LAB: (if indicated)

Developmental Follow-up:

❑ No delays ❑ Follow-up in office ❑ Referral

Referral: (if indicated) ❑ Vision

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 in 2 months ______________
- ❑ Follow-up hearing screen if at risk ______________
- ❑ Other/referral based on risk assessment ______________

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Signature ______________ Date ________

ATTACH LABEL

NOTES

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