EPSDT-Iowa Child Health and Development Record

6 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 (4-8 oz/day)_____________oz/day
- ❑ Baby food ________________________

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

Daily Oral Care: ❑ Yes ❑ No ❑ No teeth

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______________
- ◯ ◯ Night feedings ______________
- ◯ ◯ Bottle in bed ______________

RISK ASSESSMENT

HIGH LOW
- ◯ ◯ Vision Concerns ______________
- ◯ ◯ Hearing Concerns ______________
- ◯ ◯ Lead ______________
- ◯ ◯ TB ______________

DEVELOPMENT:

Screen or refer if concerns

YES NO
- ◯ ◯ Knows familiar people
- ◯ ◯ Laughs
- ◯ ◯ Takes turns making sounds with you
- ◯ ◯ Makes squealing noises
- ◯ ◯ Puts things in her mouth to explore them
- ◯ ◯ Reaches to grab a toy he wants
- ◯ ◯ Rolls from tummy to back
- ◯ ◯ Leans on hands to support himself when sitting

Caregiver concerns about growth, development, behavior:

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
- ❑ Time for self & partner
- ❑ Sibling adjustment to infant
- ❑ Plan for return to work
- ❑ Resources for local child care

FAMILY NUTRITION/ORAL HEALTH:
- ❑ Feed infant based on hunger cues; soft finger foods.
- ❑ Avoid milk, fish, shellfish, egg whites, peanuts, and nuts
- ❑ Provide water in a sippy cup
- ❑ No honey until 1 year
- ❑ No bottle propping

BEHAVIOR:
- ❑ Importance of talking, reading, singing, cuddling
- ❑ Emerging infant independence
- ❑ Sleep routine: self-calming, putting self to sleep

SAFETY:
- ❑ 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 ❑ Influenza ❑ COVID-19

❑ 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

Fluoride Varnish

❑ If teeth are erupted, apply fluoride in the office if not done elsewhere in the last 3 months ______________________________

LAB: (if indicated)

Developmental Follow-up:

❑ No delays ❑ Follow-up in office ❑ Referral

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

1st Five Healthy Mental Development Initiative: In available counties, contact 1st Five for developmental concerns or needs assessment at https://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: https://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 3 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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