

EPSDT-Iowa Child Health and Development Record

0-4 Week Well Exam

Name				Accompanied by	
Date	MRN	Date of Birth	Sex <input type="radio"/> M <input type="radio"/> 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 City tap Filtered/bottled

Source: 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 Metabolic Normal Abnormal

Screening: Hearing Pass Refer/Fail
 Critical congenital heart disease Pass Fail

RISK ASSESSMENT

HIGH	LOW	
<input type="radio"/>	<input type="radio"/>	Vision Concerns _____
<input type="radio"/>	<input type="radio"/>	Hearing Concerns _____
<input type="radio"/>	<input type="radio"/>	TB Risk _____

DEVELOPMENT: Screen or refer if concerns

YES	NO	
<input type="radio"/>	<input type="radio"/>	Focuses on faces
<input type="radio"/>	<input type="radio"/>	Responds to sound
<input type="radio"/>	<input type="radio"/>	Lifts head briefly when prone
<input type="radio"/>	<input type="radio"/>	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

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 examination 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:

ATTACH LABEL

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 3/8" 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 _____

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NOTES

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