

# 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

<b>HIGH</b>	<b>LOW</b>	
<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

<b>YES</b>	<b>NO</b>	
<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?

<input type="checkbox"/> Getting enough to eat	<input type="checkbox"/> Relationships	<input type="checkbox"/> Drug abuse
<input type="checkbox"/> Violence/Abuse	<input type="checkbox"/> Financial	<input type="checkbox"/> Alcohol abuse
<input type="checkbox"/> Health Insurance	<input type="checkbox"/> Child care	
<input type="checkbox"/> 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)
<b>VITALS:</b>	Temp: _____	BP (if high risk) ____/____ (____%ile ____%ile)
		HR: _____
		Resp Rate: _____
		SpO <sub>2</sub> _____

**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](http://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](http://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:**

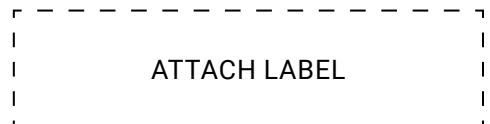
- Follow-up \_\_\_\_\_ (days/weeks/months)
- Follow-up hearing screen if at risk \_\_\_\_\_
- Other/referral based on risk assessment \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

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**NOTES**

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