



EPSDT Provider Toolkit



What is EPSDT?

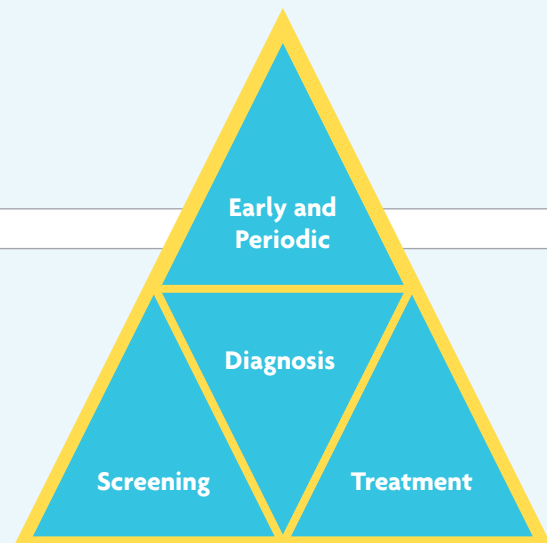
The Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) program is Medicaid's federally mandated comprehensive and preventive health program for individuals younger than 21. EPSDT is part of the Omnibus Budget Reconciliation Act of 1989 and requires states to cover all services within the scope of the federal Medicaid program. The program is designed to focus on early prevention and treatment. Requirements include periodic screening, vision, dental and hearing services.

Services include:

- Preventive screening
- Diagnosis and treatment
- Transportation and scheduling assistance
- Follow-up care with specialists

Screening must include:

- Comprehensive health history
- Mental developmental history
- Physical developmental history
- Comprehensive unclothed physical exam
- Health education, including anticipatory guidance
- Appropriate immunizations
- Laboratory tests
- Lead toxicity screening
- Vision services
- Dental services
- Hearing services
- Other necessary healthcare – diagnostic services and treatment to correct or ameliorate defects, physical and mental illnesses, and/or conditions that were discovered by the above screening services



Schedules used to determine when services are due:

- American Academy of Pediatrics Periodicity Schedule
- CDC Advisory Committee on Immunization Practices schedule

The WellCare EPSDT program supports the individual state plans by:

- Providing a repository to house EPSDT data for reporting, tracking and trending
- Mailing annual preventive care recommendations and reminders to members and providers
- Having Quality Practice Advisors to support providers
- Mailing referral letters and conducting outreach to coordinate follow-up care
- Providing EPSDT Member Outreach Coordinators

WellCare's EPSDT program includes additional member and provider outreach activities, member and provider healthy behavior rewards, and targeted care management programs.



If you have questions, contact your local
Provider Relations Representative or
Quality Practice Advisor.



WellCare Health Plans
Attn: QPA Coordinator
P.O. Box 31370
Tampa, FL 33631-3372



CPT	New Patient	CPT	Established Patient
99381	Preventive visit, Age < 1 year	99391	Preventive visit, Age < 1 year
99382	Preventive visit, Age 1-4	99392	Preventive visit, Age 1-4
99383	Preventive visit, Age 5-11	99393	Preventive visit, Age 5-11
99384	Preventive visit, Age 12-17	99394	Preventive visit, Age 12-17
99385	Preventive visit, Age 18-20	99395	Preventive visit, Age 18-20

Codes	Description
Z68.51-Z68.54	BMI percentile (use for 2-20 years of age)
97802-97804	Medical nutrition therapy
Z71.3	Dietary counseling and surveillance
Z02.5	Encounter for examination for participation in sport
Z71.82	Exercise Counseling

A Note on Modifiers and Early Periodic Screens

Modifier 25

Modifier 25 is used to describe a significant and separately identifiable E/M service above and beyond the other service provided. When a standardized screen or assessment is administered along with any E/M service (for example, preventive medicine service), both services should be reported and modifier 25 (significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service) should be appended to the E/M code to show the E/M service was distinct and necessary at the same visit.

Modifier 59

A 59 modifier identifies procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. For example, when a maternal depression screen and a health risk assessment are performed in the same visit, the 59 modifier should be appended to CPT 96161. For more information on use of a 59 modifier, please click on the following link:

<https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/downloads/modifier59.pdf>

EP Modifier

An EP modifier identifies Early and Periodic Screens and services provided in association with an Early and Periodic Screen. Any service provided in an Early and Periodic Screen should have an EP modifier. It is important to append an EP modifier to these services, as some of these CPT codes are also used for services provided to adults.



Immunization Billing Codes

CPT	Description
90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid)
90472+ (add-on code)	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid) each additional vaccine (single or combination vaccine/toxoid) List separately in addition to code for primary procedure
90473	Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid)
90474+ (add-on code)	Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) List separately in addition to code for primary procedure

Please Note:

- No intranasal vaccines are currently coverable per NCIP/VFC program.
- Currently, 90474 cannot be billed with 90473 as there are no two oral and/or intranasal vaccines or combination of an oral and intranasal vaccine that would be given to a recipient.
- 90461 is an add-on code for 90460-90461-immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine or toxoid component administered.
List separately in addition to code for primary procedure).
- Always append EP modifier to all vaccine codes.
- For all vaccines, administered after Oct. 1, 2015, providers should use ICD 10-CM code Z23.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

Quick Reference Guide

Use the chart below to be sure your practice is following the appropriate age-specific guidelines.

Children's Preventive Guidelines	Birth	3-5 days	1 month	2 months	4 months	6 months	9 months	12 months	15 months	18 months	24 months	30 months	3 years	4 years	5 years	6 years	7-20 years
History	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	Yearly
Height or length/weight	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	Yearly
Head circumference	•	•	•	•	•	•	•	•	•	•	•	•					Yearly
Body mass index (percentile if < 16 years old)											•	•	•	•	•	•	Yearly
Blood pressure ¹	*	*	*	*	*	*	*	*	*	*	*	*	•	•	•	•	Yearly
Nutrition assessment/counseling	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	Yearly
Physical activity assessment/counseling ²													•	•	•	•	Yearly
Vision exam	*	*	*	*	*	*	*	*	*	*	*	*	•	•	•	•	Yearly
Hearing exam	•	*	*	*	*	*	*	*	*	*	*	*	*	•	•	•	Yearly
Developmental assessment	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	Yearly
Psychological/Behavioral assessment	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	Yearly
Alcohol/drug use assessment and tobacco use																	Yearly
Physical exam (un clothed)	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	Yearly
Dental referral ³												•				•	Refer
Immunization assessment	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	Yearly
Hematocrit or hemoglobin					*			•		*	*	*	*	*	*	*	Yearly
Lead screening						*	*	•		*	•		*	*	*	*	
Dyslipidemia screening											*			*			*18-20
Sexually transmitted infection (STI) screening ⁴																	*11-20
Anticipatory guidance	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	Yearly
Counseling/Referral for identified problems	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	Yearly

¹Children with specific risk factors should have their blood pressure taken at visits before age 3. ²HEDIS® measure added to chart. ³Referrals for dental care should be given for any problem identified or if there is no dental home. AAPD recommends a dental exam every six months after tooth eruption. ⁴STI and cervical dysplasia screenings should be conducted on all sexually active females 11-21 years of age. *Conduct a risk assessment. If high-risk conditions exist, perform screening. HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

Notes:

- All well-visits should include, at a minimum, an unclothed physical exam, developmental assessment, anticipatory guidance, and age-appropriate screenings and immunizations, as indicated.
- Health education should include counseling for issues and risk factors, as well as inform patients about the benefits of a healthy lifestyle, safety practices/accident avoidance and disease prevention. Handouts given during an office visit without evidence of a discussion does not meet criteria for Health Education/Anticipatory Guidance.
- Screenings are as recommended by AAP and AAPD. An initial screening may be done at any time, even if the patient's age does not correspond with the periodicity schedule.
- If you require assistance with the EPSDT services due, contact us at the address below:
 - P.O. Box 31370
 - Tampa, FL 33631-3415

Recommended EPSDT Periodicity Schedule

A visit should be scheduled for all new members within 60 days. Subsequent visits should be scheduled based on the recommended guidelines.

- | | | | |
|------------|------------|-------------|---------------|
| • 3-5 days | • 4 months | • 12 months | • 24 months |
| • 1 month | • 6 months | • 15 months | • 30 months |
| • 2 months | • 9 months | • 18 months | • 3-21 yearly |

Any member who has not had the recommended services should be brought up to date as soon as possible.



Helpful Hints

- Use the list of members due or overdue for EPSDT services provided to you by WellCare and contact the member for an appointment.
- Maximize every visit by making sure the child is current on EPSDT services.
- Be sure your office uses the correct coding.

For complete information, see:

The American Academy of Pediatrics (AAP) periodicity schedule at <https://brightfutures.aap.org/clinical-practice/Pages/default.aspx> and the American Academy of Pediatric Dentistry (AAPD) guidelines at www.aapd.org/media/Policies_Guidelines/G_CariesRiskAssessment.pdf.



Immunizations

Recommended Childhood Immunizations	Birth	1 month	2 months	4 months	6 months	9 months	12 months	15 months	18 months	23 months	2-3 years	4-6 years
Hepatitis B	Hep B	Hep B			Hep B							
Rotavirus				RV								
Diphtheria, Tetanus, Pertussis				DTap				DTap				DTap
Haemophilus Influenza Type b (Hib)				Hib			Hib					
Pneumococcal				PCV			PCV					PPSV
Inactivated Poliovirus			IPV		IPV							IPV
Influenza					Influenza yearly*							
Measles, Mumps, Rubella							MMR					MMR
Varicella							Varicella					Varicella
Hepatitis A							Hep A, dose 1			Hep A series		
Meningococcal												MCV

■ Range of recommended ages for all children except certain high-risk groups

■ Range of recommended ages for certain high-risk groups

*One of the two vaccinations can be an LAIV vaccination, but it must be administered on the child's second birthday to meet criteria.

Recommended Adolescent Immunizations	7-10 years	11-12 years	13-18 years
Influenza	Influenza yearly		
Pneumococcal	PPSV		
Hepatitis A	Hep A series		
Hepatitis B	Hep B series		
Inactivated Poliovirus	IPV series		
Measles, Mumps, Rubella	MMR series		
Varicella	Varicella series		
Tetanus, Diphtheria, Pertussis		Tdap	Tdap
Human Papillomavirus		HPV (3 doses)	HPV series
Meningococcal	MCV	MCV	MCV

- Range of recommended ages for certain high-risk groups
- Range of recommended ages for catch-up immunization



For complete information, see The Advisory Committee on Immunization Practices (<https://www.cdc.gov/vaccines/acip/recs/grade/downloads/ACIP-evidence-rec-frame-508.pdf>), the American Academy of Pediatrics (www.aap.org) and the American Academy of Family Physicians (www.aafp.org). Department of Health and Human Services • Centers for Disease Control and Prevention



Preventive Care Resources

Prevention	
Adolescent Development	www.nlm.nih.gov/medlineplus/ency/article/002003.htm
Ages and Stages Questionnaires (a fee may be associated)	www.healthychildren.org
American Academy of Family Physicians	www.aafp.org
American Academy of Pediatrics – assessments, patient education, forms and other information	www.brightfutures.org
Centers for Disease Control and Prevention (CDC) Growth and BMI charts	www.cdc.gov/growthcharts/clinical_charts.htm
Health Resources and Service Administration (HRSA), Maternal and Child Health	www.mchb.hrsa.gov/epsdt
March of Dimes	www.marchofdimes.com
Medicaid EPSDT Program	www.medicaid.gov/medicaid/benefits/epsdt/index.html
Modified Checklist for Autism in Toddlers (M-CHAT) autism screening tool	https://m-chat.org/

Prevention (Continued)

National Domestic Violence Hotline	www.ndvh.org 1-800-799-SAFE (7233)
U.S. Department of Health and Human Services	www.healthfinder.gov/HealthTopics

Immunizations

CDC, Immunization Schedules	www.cdc.gov/vaccines/schedules/index.html
CDC, National Immunization Program	www.cdc.gov/vaccines
Immunization Action Coalition	www.immunize.org
Vaccine Safety	www.vaccinesafety.edu

For state-specific information and resources, please visit www.wellcare.com.

EPSDT Assessment Categories



Newborn Assessment

Category	Assessment
Physical Exam	<input type="checkbox"/> Height/Weight/BMI Percentile <input type="checkbox"/> Head circumference <input type="checkbox"/> TPR (Total Physical Response) <input type="checkbox"/> General appearance <input type="checkbox"/> Head, fontanel <input type="checkbox"/> Neck <input type="checkbox"/> Eyes, red reflex, strabismus <input type="checkbox"/> Ears, nose, mouth/throat <input type="checkbox"/> Lungs <input type="checkbox"/> Heart <input type="checkbox"/> Abdomen <input type="checkbox"/> Femoral pulses <input type="checkbox"/> Umbilical cord <input type="checkbox"/> Genitalia (male-testes, circ.) <input type="checkbox"/> Spine <input type="checkbox"/> Extremities <input type="checkbox"/> Hips <input type="checkbox"/> Skin <input type="checkbox"/> Neuro
Risk Assessment/ Screening	<input type="checkbox"/> Blood pressure <input type="checkbox"/> Hearing <input type="checkbox"/> Vision <input type="checkbox"/> Metabolic/Hemoglobinopathy
Nutrition	<input type="checkbox"/> Breastfed, how long, frequency <input type="checkbox"/> Formula, how much and how often, brand-w/iron <input type="checkbox"/> Water source – well, city or bottled <input type="checkbox"/> Number of wet diapers/day <input type="checkbox"/> Stools/day <input type="checkbox"/> WIC
Development	<input type="checkbox"/> Suck, swallow <input type="checkbox"/> Breathe easily <input type="checkbox"/> Turns, calms to mom's/dad's voice <input type="checkbox"/> Eats well
Common Problems	<input type="checkbox"/> Constipation <input type="checkbox"/> Sleep <input type="checkbox"/> Spitting up <input type="checkbox"/> Excessive crying
Behavioral/Social	<input type="checkbox"/> Parental concerns <input type="checkbox"/> Support for mother/father <input type="checkbox"/> Family makeup <input type="checkbox"/> Any major changes in family <input type="checkbox"/> Any changes in family health <input type="checkbox"/> Maternal/paternal depression
Anticipatory Guidance Topics	<input type="checkbox"/> Car seat, facing back <input type="checkbox"/> Smoke-free environment <input type="checkbox"/> Smoke detectors in home <input type="checkbox"/> Hot water temperature < 120° F <input type="checkbox"/> No bottle propping <input type="checkbox"/> Sleep on back <input type="checkbox"/> Well-fitted crib mattress, no pillows or blankets <input type="checkbox"/> Never shake baby <input type="checkbox"/> Nutrition/Feedings <input type="checkbox"/> No solid food <input type="checkbox"/> Sponge bath <input type="checkbox"/> Cord, circumcision care <input type="checkbox"/> Bowel movements <input type="checkbox"/> General newborn care <input type="checkbox"/> Taking temperature – Fever > 100.4° F <input type="checkbox"/> When to call the doctor
History	<input type="checkbox"/> Hospital course <input type="checkbox"/> Exams/Screenings <input type="checkbox"/> Hep B <input type="checkbox"/> Weeks' gestation <input type="checkbox"/> Birth weight <input type="checkbox"/> Issues/Concerns <input type="checkbox"/> Past Medical History
Plan/Referrals	<input type="checkbox"/> Immunizations status <input type="checkbox"/> Hep B #1 (if indicated) <input type="checkbox"/> Ophthalmology referral (if < 32 weeks)



1-Month Assessment

Category	Assessment
Physical Exam	<input type="checkbox"/> Height/Weight/BMI Percentile <input type="checkbox"/> Head circumference <input type="checkbox"/> TPR <input type="checkbox"/> General appearance <input type="checkbox"/> Head, fontanel <input type="checkbox"/> Neck <input type="checkbox"/> Eyes, red reflex, strabismus <input type="checkbox"/> Ears, nose, mouth/throat <input type="checkbox"/> Lungs <input type="checkbox"/> Heart <input type="checkbox"/> Abdomen <input type="checkbox"/> Femoral pulses <input type="checkbox"/> Umbilical cord <input type="checkbox"/> Genitalia (male-testes, circ.) <input type="checkbox"/> Spine <input type="checkbox"/> Extremities <input type="checkbox"/> Hips <input type="checkbox"/> Skin <input type="checkbox"/> Neuro
Risk Assessment/ Screening	<input type="checkbox"/> Blood pressure <input type="checkbox"/> Hearing <input type="checkbox"/> Vision <input type="checkbox"/> Metabolic/hemoglobinopathy <input type="checkbox"/> Tuberculosis
Nutrition	<input type="checkbox"/> Breastfed, how long, frequency <input type="checkbox"/> Formula, oz and frequency brand – w/iron <input type="checkbox"/> Water source – well, city or bottled <input type="checkbox"/> Number of wet diapers/day <input type="checkbox"/> Stools/day <input type="checkbox"/> WIC
Development	<input type="checkbox"/> Lifts head when prone <input type="checkbox"/> Begins to smile <input type="checkbox"/> Follows parent with eyes <input type="checkbox"/> Turns to parent's voices
Common Problems	<input type="checkbox"/> Constipation <input type="checkbox"/> Sleep <input type="checkbox"/> Spitting up <input type="checkbox"/> Excessive crying <input type="checkbox"/> Colic <input type="checkbox"/> Stuffy nose
Behavioral/Social	<input type="checkbox"/> Parental concerns <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Development
Social/Family History	<input type="checkbox"/> Parent/Child adjustment <input type="checkbox"/> Any major changes in family <input type="checkbox"/> Maternal/paternal depression <input type="checkbox"/> Support for mother/father <input type="checkbox"/> Sibling response to baby <input type="checkbox"/> Child care plans <input type="checkbox"/> Work plans <input type="checkbox"/> Violence or abuse
Anticipatory Guidance Topics	<input type="checkbox"/> Car seat, facing back <input type="checkbox"/> Smoke-free environment <input type="checkbox"/> Smoke detectors in home <input type="checkbox"/> Hot water temperature < 120° F <input type="checkbox"/> No bottle propping <input type="checkbox"/> Sleep on back, tummy time <input type="checkbox"/> Well-fitted crib mattress, no pillows <input type="checkbox"/> Never shake baby <input type="checkbox"/> Nutrition/Feedings <input type="checkbox"/> Techniques to calm <input type="checkbox"/> Cord, circumcision care <input type="checkbox"/> Elimination <input type="checkbox"/> Taking temperature – Fever > 100.4° F <input type="checkbox"/> When to call the doctor <input type="checkbox"/> Avoid anything around baby's neck
History	<input type="checkbox"/> Follow up previous visit <input type="checkbox"/> Medication review <input type="checkbox"/> Interval history <input type="checkbox"/> Changes in family health <input type="checkbox"/> Past Medical History
Plan/Referrals	<input type="checkbox"/> Immunizations status <input type="checkbox"/> Hep B <input type="checkbox"/> Vitamin D if breastfed <input type="checkbox"/> TB test, if at risk



2-Month Assessment

Category	Assessment
Physical Exam	<input type="checkbox"/> Height/Weight/BMI Percentile <input type="checkbox"/> Head circumference <input type="checkbox"/> TPR <input type="checkbox"/> General appearance <input type="checkbox"/> Head, fontanel <input type="checkbox"/> Neck <input type="checkbox"/> Eyes, red reflex, strabismus <input type="checkbox"/> Ears, nose, mouth/throat <input type="checkbox"/> Lungs <input type="checkbox"/> Heart <input type="checkbox"/> Abdomen <input type="checkbox"/> Femoral pulses <input type="checkbox"/> Umbilical cord <input type="checkbox"/> Genitalia (male-testes, circ.) <input type="checkbox"/> Spine <input type="checkbox"/> Extremities <input type="checkbox"/> Hips <input type="checkbox"/> Skin <input type="checkbox"/> Neuro
Risk Assessment/ Screening	<input type="checkbox"/> Blood pressure <input type="checkbox"/> Hearing <input type="checkbox"/> Vision <input type="checkbox"/> Metabolic/hemoglobinopathy
Nutrition	<input type="checkbox"/> Breastfed, how long, frequency <input type="checkbox"/> Formula, oz and frequency brand – w/iron <input type="checkbox"/> Cereal <input type="checkbox"/> Water source – well, city or bottled <input type="checkbox"/> Stools/day <input type="checkbox"/> WIC
Development	<input type="checkbox"/> Begins to push up when prone <input type="checkbox"/> Holds head up when held <input type="checkbox"/> Begins to smile <input type="checkbox"/> Follows parent with eyes <input type="checkbox"/> Turns to parent's voice <input type="checkbox"/> Coos <input type="checkbox"/> Self-comfort <input type="checkbox"/> Cries when bored (no activity) <input type="checkbox"/> Symmetrical movement
Common Problems	<input type="checkbox"/> Constipation <input type="checkbox"/> Sleep <input type="checkbox"/> Spitting up <input type="checkbox"/> Excessive crying <input type="checkbox"/> Colic <input type="checkbox"/> Stuffy nose <input type="checkbox"/> Diaper rash
Behavioral/Social	<input type="checkbox"/> Parental concerns <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Development
Social/Family History	<input type="checkbox"/> Parent/Child adjustment <input type="checkbox"/> Any major changes in family <input type="checkbox"/> Maternal/paternal depression <input type="checkbox"/> Support for mother /father <input type="checkbox"/> Sibling response to baby <input type="checkbox"/> Child care plans <input type="checkbox"/> Working out of the home <input type="checkbox"/> Violence or abuse
Anticipatory Guidance Topics	<input type="checkbox"/> Car seat, facing back <input type="checkbox"/> Smoke-free environment <input type="checkbox"/> Smoke detectors in home <input type="checkbox"/> Hot water temperature < 120° F <input type="checkbox"/> Bath safety <input type="checkbox"/> No bottle propping <input type="checkbox"/> Sleep on back, tummy time <input type="checkbox"/> Crib safety <input type="checkbox"/> Never shake baby <input type="checkbox"/> Nutrition/Feedings <input type="checkbox"/> Delay solids <input type="checkbox"/> Elimination <input type="checkbox"/> Techniques to calm <input type="checkbox"/> Rolling over – prevent falls <input type="checkbox"/> When to call the doctor
History	<input type="checkbox"/> Follow up previous visit <input type="checkbox"/> Medication review <input type="checkbox"/> Interval history <input type="checkbox"/> Special healthcare needs <input type="checkbox"/> Changes in family health <input type="checkbox"/> Past Medical History
Plan/Referrals	<input type="checkbox"/> Immunizations status <input type="checkbox"/> DTaP, IPV, Hib, Hep B, PCV-7 <input type="checkbox"/> Rotavirus vaccine <input type="checkbox"/> Vitamin D if breastfed



4-Month Assessment

Category	Assessment
Physical Exam	<input type="checkbox"/> Height/Weight/BMI Percentile <input type="checkbox"/> Head circumference <input type="checkbox"/> TPR <input type="checkbox"/> General appearance <input type="checkbox"/> Head, fontanel <input type="checkbox"/> Neck <input type="checkbox"/> Eyes, red reflex, strabismus <input type="checkbox"/> Ears, nose, mouth/throat <input type="checkbox"/> Lungs <input type="checkbox"/> Heart <input type="checkbox"/> Abdomen <input type="checkbox"/> Femoral pulses <input type="checkbox"/> Umbilical cord <input type="checkbox"/> Genitalia (male-testes, circ.) <input type="checkbox"/> Spine <input type="checkbox"/> Extremities <input type="checkbox"/> Hips <input type="checkbox"/> Skin <input type="checkbox"/> Neuro
Risk Assessment/ Screening	<input type="checkbox"/> Blood pressure <input type="checkbox"/> Hearing <input type="checkbox"/> Vision <input type="checkbox"/> Anemia risk assessment
Nutrition	<input type="checkbox"/> Breastfed, how long, frequency <input type="checkbox"/> Formula, oz and frequency brand – w/iron <input type="checkbox"/> Cereal <input type="checkbox"/> Water source – well, city or bottled <input type="checkbox"/> Other liquids <input type="checkbox"/> WIC
Development	<input type="checkbox"/> Push up to elbows when prone <input type="checkbox"/> Head control <input type="checkbox"/> Rolls and reaches for objects <input type="checkbox"/> Responds to affection <input type="checkbox"/> Babbles and coos <input type="checkbox"/> Self-comfort
Common Problems	<input type="checkbox"/> Constipation <input type="checkbox"/> Sleep <input type="checkbox"/> Spitting up <input type="checkbox"/> Excessive crying <input type="checkbox"/> Colic <input type="checkbox"/> Stuffy nose <input type="checkbox"/> Diaper rash
Behavioral/Social	<input type="checkbox"/> Parental concerns <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Development
Social/Family History	<input type="checkbox"/> Any major changes in family <input type="checkbox"/> Family support <input type="checkbox"/> Working out of the home <input type="checkbox"/> Child care <input type="checkbox"/> Violence or abuse
Anticipatory Guidance Topics	<input type="checkbox"/> Car seat, facing back <input type="checkbox"/> Smoke-free environment <input type="checkbox"/> Smoke detectors in home <input type="checkbox"/> Sleep and daily routines <input type="checkbox"/> Hot water temperature < 120° F <input type="checkbox"/> Bath safety <input type="checkbox"/> No bottle propping <input type="checkbox"/> Sleep on back, tummy time <input type="checkbox"/> Crib safety <input type="checkbox"/> Never shake baby <input type="checkbox"/> Nutrition/Feedings <input type="checkbox"/> Solid foods – when and how to add <input type="checkbox"/> Weight gain <input type="checkbox"/> Rolling over – prevent falls <input type="checkbox"/> Choking
History	<input type="checkbox"/> Follow up previous visit <input type="checkbox"/> Medication review <input type="checkbox"/> Interval history <input type="checkbox"/> Special healthcare needs <input type="checkbox"/> Changes in family health <input type="checkbox"/> Past Medical History
Plan/Referrals	<input type="checkbox"/> Immunizations status <input type="checkbox"/> DTaP, IPV, Hib, Hep B, PCV-7 <input type="checkbox"/> Rotavirus vaccine <input type="checkbox"/> Vitamin D if breastfed



6-Month Assessment

Category	Assessment
Physical Exam	<input type="checkbox"/> Height/Weight/BMI Percentile <input type="checkbox"/> Head circumference <input type="checkbox"/> TPR <input type="checkbox"/> General appearance <input type="checkbox"/> Head, fontanel <input type="checkbox"/> Neck <input type="checkbox"/> Eyes, red reflex, strabismus <input type="checkbox"/> Ears, nose, mouth/throat <input type="checkbox"/> Lungs <input type="checkbox"/> Heart <input type="checkbox"/> Abdomen <input type="checkbox"/> Femoral pulses <input type="checkbox"/> Umbilical cord <input type="checkbox"/> Genitalia (male-testes, circ.) <input type="checkbox"/> Spine <input type="checkbox"/> Extremities <input type="checkbox"/> Hips <input type="checkbox"/> Skin <input type="checkbox"/> Neuro
Risk Assessment/ Screening	<input type="checkbox"/> Blood pressure <input type="checkbox"/> Hearing <input type="checkbox"/> Vision <input type="checkbox"/> Anemia risk assessment <input type="checkbox"/> Tuberculosis risk screening <input type="checkbox"/> Dental/Oral <input type="checkbox"/> Lead risk screening
Nutrition	<input type="checkbox"/> Breastfed, how long, frequency <input type="checkbox"/> Formula, oz and frequency brand – w/iron <input type="checkbox"/> Cereal <input type="checkbox"/> Water source – well, city or bottled <input type="checkbox"/> Other liquids <input type="checkbox"/> WIC
Development	<input type="checkbox"/> Able to sit briefly <input type="checkbox"/> Head control <input type="checkbox"/> Rolls and reaches for objects <input type="checkbox"/> Responds to affection <input type="checkbox"/> Jabbers and laughs <input type="checkbox"/> Self-comfort <input type="checkbox"/> Puts things in mouth
Common Problems	<input type="checkbox"/> Constipation <input type="checkbox"/> Sleep <input type="checkbox"/> Spitting up <input type="checkbox"/> Excessive crying <input type="checkbox"/> Colic <input type="checkbox"/> Stuffy nose <input type="checkbox"/> Diaper rash
Behavioral/Social	<input type="checkbox"/> Parental concerns <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Development
Social/Family History	<input type="checkbox"/> Any major changes in family <input type="checkbox"/> Family support <input type="checkbox"/> Working out of the home <input type="checkbox"/> Child care <input type="checkbox"/> Violence or abuse <input type="checkbox"/> Talk, read to baby
Anticipatory Guidance Topics	<input type="checkbox"/> Car seat, facing back <input type="checkbox"/> Smoke-free environment <input type="checkbox"/> Smoke detectors in home <input type="checkbox"/> Sleep and daily routines <input type="checkbox"/> Hot water temperature < 120° F <input type="checkbox"/> Drowning <input type="checkbox"/> No bottle propping <input type="checkbox"/> Sleep on back, tummy time <input type="checkbox"/> Kitchen safety <input type="checkbox"/> Brushing teeth <input type="checkbox"/> Nutrition/Feedings <input type="checkbox"/> Solid foods – when and how to add <input type="checkbox"/> Drinking from a cup <input type="checkbox"/> Rolling over – prevent falls <input type="checkbox"/> Choking – finger foods <input type="checkbox"/> Teething
History	<input type="checkbox"/> Follow up previous visit <input type="checkbox"/> Medication review <input type="checkbox"/> Interval history <input type="checkbox"/> Special healthcare needs <input type="checkbox"/> Changes in family health <input type="checkbox"/> Past Medical History
Plan/Referrals	<input type="checkbox"/> Immunizations status <input type="checkbox"/> DTaP, IPV, Hib, Hep B, PCV-7 <input type="checkbox"/> Rotavirus vaccine <input type="checkbox"/> Vitamin D if breastfed <input type="checkbox"/> Lead screening, if at risk <input type="checkbox"/> TB test, if at risk <input type="checkbox"/> Fluoride, if indicated



9-Month Assessment

Category	Assessment
Physical Exam	<input type="checkbox"/> Height/Weight/BMI Percentile <input type="checkbox"/> Head circumference <input type="checkbox"/> TPR <input type="checkbox"/> General appearance <input type="checkbox"/> Head, fontanel <input type="checkbox"/> Neck <input type="checkbox"/> Eyes, red reflex, strabismus <input type="checkbox"/> Ears, nose, mouth/throat <input type="checkbox"/> Dental – caries, staining, spots <input type="checkbox"/> Lungs <input type="checkbox"/> Heart <input type="checkbox"/> Abdomen <input type="checkbox"/> Femoral pulses <input type="checkbox"/> Umbilical cord <input type="checkbox"/> Genitalia (male-testes, circ.) <input type="checkbox"/> Spine <input type="checkbox"/> Extremities <input type="checkbox"/> Hips <input type="checkbox"/> Skin <input type="checkbox"/> Neuro
Risk Assessment/ Screening	<input type="checkbox"/> Blood pressure <input type="checkbox"/> Hearing <input type="checkbox"/> Vision <input type="checkbox"/> Dental/Oral <input type="checkbox"/> Lead risk screening
Nutrition	<input type="checkbox"/> Breastfed, how long, frequency <input type="checkbox"/> Formula, oz and frequency brand – w/iron <input type="checkbox"/> Cereal <input type="checkbox"/> Water source – well, city, bottled or fluoridated <input type="checkbox"/> Other liquids <input type="checkbox"/> WIC
Development	<input type="checkbox"/> Sits well <input type="checkbox"/> Pulls to stand <input type="checkbox"/> Crawls <input type="checkbox"/> Imitates sounds <input type="checkbox"/> Plays peek-a-boo <input type="checkbox"/> Puts things in mouth <input type="checkbox"/> Looks for dropped items
Behavioral/Social	<input type="checkbox"/> Parental concerns <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Development <input type="checkbox"/> Goes to parent for comfort <input type="checkbox"/> Stranger anxiety
Social/Family History	<input type="checkbox"/> Any major changes in family <input type="checkbox"/> Family support <input type="checkbox"/> Child care <input type="checkbox"/> Violence or abuse <input type="checkbox"/> Talk, read to baby
Anticipatory Guidance Topics	<input type="checkbox"/> Car seat safety <input type="checkbox"/> Smoke-free environment <input type="checkbox"/> Smoke detectors in home <input type="checkbox"/> Sleep and daily routines <input type="checkbox"/> Burns <input type="checkbox"/> Drowning <input type="checkbox"/> Age-appropriate discipline <input type="checkbox"/> No bottle in bed or propping <input type="checkbox"/> First dental visit <input type="checkbox"/> Child-proof home <input type="checkbox"/> Brushing teeth <input type="checkbox"/> Solid foods <input type="checkbox"/> Self-feeding <input type="checkbox"/> Choking – finger foods <input type="checkbox"/> Drinking from a cup <input type="checkbox"/> Separation anxiety <input type="checkbox"/> Falls/Window guards <input type="checkbox"/> Poisons <input type="checkbox"/> No TV <input type="checkbox"/> Teething
History	<input type="checkbox"/> Follow up previous visit <input type="checkbox"/> Medication review <input type="checkbox"/> Interval history <input type="checkbox"/> Special healthcare needs <input type="checkbox"/> Changes in family health <input type="checkbox"/> Past Medical History
Plan/Referrals	<input type="checkbox"/> Immunizations status <input type="checkbox"/> Hep B <input type="checkbox"/> Catch up immunizations <input type="checkbox"/> Dental, if at risk <input type="checkbox"/> Lead screening, if at risk <input type="checkbox"/> Fluoride, if indicated



12-Month Assessment

Category	Assessment
Physical Exam	<input type="checkbox"/> Height/Weight/BMI Percentile <input type="checkbox"/> Head circumference <input type="checkbox"/> TPR <input type="checkbox"/> General appearance <input type="checkbox"/> Head, fontanel <input type="checkbox"/> Neck <input type="checkbox"/> Eyes, red reflex, alignment <input type="checkbox"/> Ears, nose, mouth/throat <input type="checkbox"/> Dental – caries, staining, spots <input type="checkbox"/> Lungs <input type="checkbox"/> Heart <input type="checkbox"/> Abdomen <input type="checkbox"/> Femoral pulses <input type="checkbox"/> Umbilical cord <input type="checkbox"/> Genitalia (male-testes) <input type="checkbox"/> Spine <input type="checkbox"/> Extremities <input type="checkbox"/> Hips <input type="checkbox"/> Skin <input type="checkbox"/> Neuro
Risk Assessment/ Screening	<input type="checkbox"/> Blood pressure <input type="checkbox"/> Hearing <input type="checkbox"/> Vision <input type="checkbox"/> Anemia screening <input type="checkbox"/> Dental/Oral <input type="checkbox"/> Lead risk screening <input type="checkbox"/> TB risk assessment
Nutrition	<input type="checkbox"/> Breastfed, how long, frequency <input type="checkbox"/> Formula, oz and frequency brand – w/iron <input type="checkbox"/> Cereal <input type="checkbox"/> Water source – well, city, bottled or fluoridated <input type="checkbox"/> Other liquids <input type="checkbox"/> WIC <input type="checkbox"/> Bottle Weaning
Development	<input type="checkbox"/> Waves bye <input type="checkbox"/> Pulls to stand, walks holding on <input type="checkbox"/> Copies gestures <input type="checkbox"/> Imitates sounds <input type="checkbox"/> Plays peek-a-boo <input type="checkbox"/> Follows simple directions <input type="checkbox"/> Speaks one or two words <input type="checkbox"/> Drinks from a cup
Behavioral/Social	<input type="checkbox"/> Parental concerns <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Development <input type="checkbox"/> Praise for good behavior <input type="checkbox"/> Stranger anxiety <input type="checkbox"/> Separation anxiety
Social/Family History	<input type="checkbox"/> Any major changes in family <input type="checkbox"/> Family support <input type="checkbox"/> Child care <input type="checkbox"/> Violence or abuse
Anticipatory Guidance Topics	<input type="checkbox"/> Car seat safety <input type="checkbox"/> Smoke-free environment <input type="checkbox"/> Smoke detectors in home <input type="checkbox"/> Sleep and daily routines <input type="checkbox"/> Burns <input type="checkbox"/> Drowning <input type="checkbox"/> Age-appropriate discipline <input type="checkbox"/> No bottle in bed or propping <input type="checkbox"/> Bottle weaning <input type="checkbox"/> Child-proof home <input type="checkbox"/> Brushing teeth <input type="checkbox"/> Solid foods <input type="checkbox"/> Self-feeding <input type="checkbox"/> Choking – finger foods <input type="checkbox"/> Drinking from a cup <input type="checkbox"/> Separation anxiety <input type="checkbox"/> Falls/Window guards <input type="checkbox"/> Poisons <input type="checkbox"/> No TV
History	<input type="checkbox"/> Follow up previous visit <input type="checkbox"/> Medication review <input type="checkbox"/> Interval history <input type="checkbox"/> Special healthcare needs <input type="checkbox"/> Changes/Concerns – child health <input type="checkbox"/> Changes in family health <input type="checkbox"/> Past Medical History
Plan/Referrals	<input type="checkbox"/> Immunizations status <input type="checkbox"/> Varicella, PCV-7, Hib, Hep B, Hep A, IPV, MMR, influenza <input type="checkbox"/> Catch-up immunizations <input type="checkbox"/> Vitamin D if breastfed <input type="checkbox"/> Dental home or referral <input type="checkbox"/> Blood lead screen <input type="checkbox"/> TB test, if at risk <input type="checkbox"/> Hematocrit or hemoglobin



15-Month Assessment

Category	Assessment
Physical Exam	<input type="checkbox"/> Height/Weight/BMI Percentile <input type="checkbox"/> Head circumference <input type="checkbox"/> TPR <input type="checkbox"/> General appearance <input type="checkbox"/> Head, fontanel <input type="checkbox"/> Neck <input type="checkbox"/> Eyes, red reflex, alignment <input type="checkbox"/> Ears, nose, mouth/throat <input type="checkbox"/> Dental – caries, staining, spots <input type="checkbox"/> Lungs <input type="checkbox"/> Heart <input type="checkbox"/> Abdomen <input type="checkbox"/> Femoral pulses <input type="checkbox"/> Umbilical cord <input type="checkbox"/> Genitalia (male-testes) <input type="checkbox"/> Spine <input type="checkbox"/> Extremities <input type="checkbox"/> Hips <input type="checkbox"/> Skin <input type="checkbox"/> Neuro
Risk Assessment/ Screening	<input type="checkbox"/> Blood pressure <input type="checkbox"/> Hearing <input type="checkbox"/> Vision
Nutrition	<input type="checkbox"/> Breastfed, how long, frequency <input type="checkbox"/> Formula, oz and frequency brand – w/iron <input type="checkbox"/> Cereal <input type="checkbox"/> Water source – well, city, bottled or fluoridated <input type="checkbox"/> Other liquids <input type="checkbox"/> WIC <input type="checkbox"/> Bottle weaning
Development	<input type="checkbox"/> Says two or three words <input type="checkbox"/> Walks well <input type="checkbox"/> Bends down without falling <input type="checkbox"/> Scribbles <input type="checkbox"/> Tries to do what others do <input type="checkbox"/> Follows simple commands <input type="checkbox"/> Listens to a story <input type="checkbox"/> Puts a block in a cup
Behavioral/Social	<input type="checkbox"/> Parental concerns <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Development <input type="checkbox"/> Temper tantrums <input type="checkbox"/> Discourage hitting, biting, other aggressive behaviors
Social/Family History	<input type="checkbox"/> Any major changes in family <input type="checkbox"/> Family support <input type="checkbox"/> Violence or abuse <input type="checkbox"/> Talk, read to baby
Anticipatory Guidance Topics	<input type="checkbox"/> Car seat safety <input type="checkbox"/> Carbon monoxide detectors <input type="checkbox"/> Smoke detectors in home <input type="checkbox"/> Child-proof home <input type="checkbox"/> Age-appropriate discipline <input type="checkbox"/> Consistent bedtime routine <input type="checkbox"/> Burns <input type="checkbox"/> First dentist visit <input type="checkbox"/> Puts a block in a cup <input type="checkbox"/> Healthy food/snack choices <input type="checkbox"/> Whole milk <input type="checkbox"/> Falls <input type="checkbox"/> Poisons <input type="checkbox"/> No TV
History	<input type="checkbox"/> Follow up previous visit <input type="checkbox"/> Medication review <input type="checkbox"/> Interval history <input type="checkbox"/> Special healthcare needs <input type="checkbox"/> Changes in family health <input type="checkbox"/> Past Medical History
Plan/Referrals	<input type="checkbox"/> Immunizations status <input type="checkbox"/> MMR, Hib, Varicella, PCV-7 Hep B, Hep A, DTaP, influenza <input type="checkbox"/> Catch-up immunizations <input type="checkbox"/> Fluoride, if indicated <input type="checkbox"/> Dental home or referral <input type="checkbox"/> Blood lead screen <input type="checkbox"/> TB test, if at risk



18-Month Assessment

Category	Assessment
Physical Exam	<input type="checkbox"/> Height/Weight/BMI Percentile <input type="checkbox"/> Head circumference <input type="checkbox"/> TPR <input type="checkbox"/> General appearance <input type="checkbox"/> Head, fontanel <input type="checkbox"/> Neck <input type="checkbox"/> Eyes, red reflex, alignment <input type="checkbox"/> Ears, nose, mouth/throat <input type="checkbox"/> Dental – caries, staining, spots <input type="checkbox"/> Lungs <input type="checkbox"/> Heart <input type="checkbox"/> Abdomen <input type="checkbox"/> Femoral pulses <input type="checkbox"/> Umbilical cord <input type="checkbox"/> Genitalia (male-testes) <input type="checkbox"/> Spine <input type="checkbox"/> Extremities <input type="checkbox"/> Hips <input type="checkbox"/> Skin <input type="checkbox"/> Neuro
Risk Assessment/ Screening	<input type="checkbox"/> Blood pressure <input type="checkbox"/> Hearing <input type="checkbox"/> Vision <input type="checkbox"/> Anemia risk screening <input type="checkbox"/> Lead risk assessment <input type="checkbox"/> Tuberculosis risk assessment <input type="checkbox"/> Autism screening
Nutrition	<input type="checkbox"/> Bottle Weaning, breastfed <input type="checkbox"/> Fruits <input type="checkbox"/> Vegetables <input type="checkbox"/> Meat <input type="checkbox"/> Appetite <input type="checkbox"/> Dairy <input type="checkbox"/> Water source – well, city, bottled or fluoridated <input type="checkbox"/> WIC
Development	<input type="checkbox"/> Says six words <input type="checkbox"/> Walks up steps <input type="checkbox"/> Runs <input type="checkbox"/> Laughs in response to others <input type="checkbox"/> Points to one body part <input type="checkbox"/> Uses spoon and cup <input type="checkbox"/> Stacks two blocks <input type="checkbox"/> Points at objects <input type="checkbox"/> Helps to dress/undress
Behavioral/Social	<input type="checkbox"/> Parental concerns <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Development <input type="checkbox"/> Temper tantrums – timeouts <input type="checkbox"/> Discourage hitting, biting, other aggressive behaviors
Social/Family History	<input type="checkbox"/> Any major changes in family <input type="checkbox"/> Family support <input type="checkbox"/> Violence or abuse <input type="checkbox"/> Talk, read, sing to baby
Anticipatory Guidance Topics	<input type="checkbox"/> Car seat safety <input type="checkbox"/> Carbon monoxide detectors <input type="checkbox"/> Smoke detectors in home <input type="checkbox"/> Child-proof home (e.g. electrical outlets, locks) <input type="checkbox"/> Age-appropriate discipline <input type="checkbox"/> Consistent bedtime routine <input type="checkbox"/> Burns <input type="checkbox"/> First dentist visit <input type="checkbox"/> Healthy food/snack choices <input type="checkbox"/> Whole milk <input type="checkbox"/> Falls <input type="checkbox"/> Poisons <input type="checkbox"/> No TV <input type="checkbox"/> Toilet training readiness
History	<input type="checkbox"/> Follow up previous visit <input type="checkbox"/> Medication review <input type="checkbox"/> Interval history <input type="checkbox"/> Special healthcare needs <input type="checkbox"/> Changes in family health <input type="checkbox"/> Past Medical History
Plan/Referrals	<input type="checkbox"/> Immunizations status <input type="checkbox"/> DTaP, MMR, Hep B, Hep A, <input type="checkbox"/> Influenza <input type="checkbox"/> Catch-up immunizations <input type="checkbox"/> Fluoride, if indicated <input type="checkbox"/> Dental home or referral <input type="checkbox"/> Lead screen, if at risk <input type="checkbox"/> TB test, if at risk



24-Month Assessment

Category	Assessment
Physical Exam	<input type="checkbox"/> Height/Weight/BMI Percentile <input type="checkbox"/> Head circumference <input type="checkbox"/> TPR <input type="checkbox"/> General appearance <input type="checkbox"/> Head, fontanel <input type="checkbox"/> Neck <input type="checkbox"/> Eyes, red reflex, alignment <input type="checkbox"/> Ears, nose, mouth/throat <input type="checkbox"/> Dental – caries, staining, spots <input type="checkbox"/> Lungs <input type="checkbox"/> Heart <input type="checkbox"/> Abdomen <input type="checkbox"/> Femoral pulses <input type="checkbox"/> Umbilical cord <input type="checkbox"/> Genitalia (male-testes) <input type="checkbox"/> Spine <input type="checkbox"/> Extremities <input type="checkbox"/> Hips <input type="checkbox"/> Skin <input type="checkbox"/> Neuro
Risk Assessment/ Screening	<input type="checkbox"/> Blood pressure <input type="checkbox"/> Hearing <input type="checkbox"/> Vision <input type="checkbox"/> Anemia risk screening <input type="checkbox"/> Lead risk assessment <input type="checkbox"/> Tuberculosis risk assessment <input type="checkbox"/> Autism screening <input type="checkbox"/> Dyslipidemia risk assessment
Nutrition	<input type="checkbox"/> Bottle Weaning, breastfed <input type="checkbox"/> Fruits <input type="checkbox"/> Vegetables <input type="checkbox"/> Meat <input type="checkbox"/> Appetite <input type="checkbox"/> Dairy <input type="checkbox"/> Water source – well, city, bottled or fluoridated <input type="checkbox"/> WIC
Development	<input type="checkbox"/> Says 6 words <input type="checkbox"/> Stands on tiptoe <input type="checkbox"/> Runs <input type="checkbox"/> Knows names of familiar people and body parts <input type="checkbox"/> Plays alongside other children <input type="checkbox"/> Throws a ball overhand <input type="checkbox"/> Stacks 5-6 blocks <input type="checkbox"/> Turns pages of book one at a time
Behavioral/Social	<input type="checkbox"/> Parental concerns <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Development <input type="checkbox"/> Temper tantrums – timeouts <input type="checkbox"/> Playing with other children <input type="checkbox"/> Self-expression
Social/Family History	<input type="checkbox"/> Any major changes in family <input type="checkbox"/> Family support <input type="checkbox"/> Violence or abuse <input type="checkbox"/> Talk, read, sing to baby <input type="checkbox"/> Model appropriate language <input type="checkbox"/> Screen time
Anticipatory Guidance Topics	<input type="checkbox"/> Car seat safety <input type="checkbox"/> Carbon monoxide detectors <input type="checkbox"/> Smoke detectors in home <input type="checkbox"/> Child-proof home <input type="checkbox"/> Age-appropriate discipline <input type="checkbox"/> Consistent bedtime routine <input type="checkbox"/> Burns <input type="checkbox"/> Physical activity <input type="checkbox"/> Bike helmet <input type="checkbox"/> Picky eater <input type="checkbox"/> Outside Supervision <input type="checkbox"/> Guns <input type="checkbox"/> Poisons <input type="checkbox"/> Limit TV to 1-2 hrs/day <input type="checkbox"/> Toilet training
History	<input type="checkbox"/> Follow up previous visit <input type="checkbox"/> Medication review <input type="checkbox"/> Interval history <input type="checkbox"/> Special healthcare needs <input type="checkbox"/> Changes in family health <input type="checkbox"/> Past Medical History
Plan/Referrals	<input type="checkbox"/> Immunizations status <input type="checkbox"/> Hep A, influenza <input type="checkbox"/> Catch-up immunizations <input type="checkbox"/> Fluoride, if indicated <input type="checkbox"/> Dental home or referral <input type="checkbox"/> Blood lead screen <input type="checkbox"/> Autism screening <input type="checkbox"/> Lipid profile, if at risk <input type="checkbox"/> TB test, if at risk



30-Month Assessment

Category	Assessment
Physical Exam	<input type="checkbox"/> Height/Weight/BMI Percentile <input type="checkbox"/> TPR <input type="checkbox"/> General appearance <input type="checkbox"/> Head, fontanel <input type="checkbox"/> Neck <input type="checkbox"/> Eyes, red reflex, alignment <input type="checkbox"/> Ears, nose, mouth/throat <input type="checkbox"/> Dental – caries, staining, spots <input type="checkbox"/> Lungs <input type="checkbox"/> Heart <input type="checkbox"/> Abdomen <input type="checkbox"/> Femoral pulses <input type="checkbox"/> Genitalia (male-testes) <input type="checkbox"/> Spine <input type="checkbox"/> Extremities <input type="checkbox"/> Hips <input type="checkbox"/> Skin <input type="checkbox"/> Neuro
Risk Assessment/ Screening	<input type="checkbox"/> Blood pressure <input type="checkbox"/> Hearing <input type="checkbox"/> Vision <input type="checkbox"/> Dental home
Nutrition	<input type="checkbox"/> Bottle Weaning, breastfed <input type="checkbox"/> Fruits <input type="checkbox"/> Vegetables <input type="checkbox"/> Meat <input type="checkbox"/> Appetite <input type="checkbox"/> Dairy <input type="checkbox"/> Water source – well, city, bottled or fluoridated <input type="checkbox"/> WIC
Development	<input type="checkbox"/> Puts 3-4 words together <input type="checkbox"/> Jumps up and down <input type="checkbox"/> Washes and dries hands <input type="checkbox"/> Knows animal sounds
Behavioral/Social	<input type="checkbox"/> Parental concerns <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Development <input type="checkbox"/> Plays with other children <input type="checkbox"/> Screen time < 2 hours <input type="checkbox"/> Temperament <input type="checkbox"/> Set limits
Social/Family History	<input type="checkbox"/> Changes since last visit <input type="checkbox"/> Parents working outside home <input type="checkbox"/> Child care type <input type="checkbox"/> Daily reading <input type="checkbox"/> Preschool
Anticipatory Guidance Topics	<input type="checkbox"/> Car seat safety <input type="checkbox"/> Carbon monoxide detectors <input type="checkbox"/> Smoke detectors in home <input type="checkbox"/> Child-proof home <input type="checkbox"/> Outdoor safety <input type="checkbox"/> Consistent routines <input type="checkbox"/> Sun exposure <input type="checkbox"/> Physical activity <input type="checkbox"/> Bike helmet <input type="checkbox"/> Picky eater <input type="checkbox"/> Supervise outside <input type="checkbox"/> Guns <input type="checkbox"/> Poisons <input type="checkbox"/> Limit TV to 1-2 hrs/day <input type="checkbox"/> Toilet training
History	<input type="checkbox"/> Follow up previous visit <input type="checkbox"/> Medication review <input type="checkbox"/> Interval history <input type="checkbox"/> Special healthcare needs <input type="checkbox"/> Changes in family health <input type="checkbox"/> Past Medical History
Plan/Referrals	<input type="checkbox"/> Immunizations status <input type="checkbox"/> Influenza <input type="checkbox"/> Catch-up immunizations <input type="checkbox"/> Fluoride, if indicated <input type="checkbox"/> Dental home or referral



3-Year Assessment

Category	Assessment
Physical Exam	<input type="checkbox"/> Height/Weight/BMI Percentile <input type="checkbox"/> TPR – blood pressure <input type="checkbox"/> General appearance <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Eyes <input type="checkbox"/> Ears, nose, mouth/throat <input type="checkbox"/> Dental – caries, staining, spots <input type="checkbox"/> Lungs <input type="checkbox"/> Heart <input type="checkbox"/> Abdomen <input type="checkbox"/> Femoral pulses <input type="checkbox"/> Genitalia (male-testes) <input type="checkbox"/> Spine <input type="checkbox"/> Extremities <input type="checkbox"/> Hips <input type="checkbox"/> Skin <input type="checkbox"/> Neuro
Risk Assessment/ Screening	<input type="checkbox"/> Hearing <input type="checkbox"/> Vision <input type="checkbox"/> Dental referral <input type="checkbox"/> Anemia risk screening <input type="checkbox"/> Lead risk screening <input type="checkbox"/> Tuberculosis risk screening
Nutrition	<input type="checkbox"/> Fruits <input type="checkbox"/> Vegetables <input type="checkbox"/> Meat <input type="checkbox"/> Appetite <input type="checkbox"/> Dairy <input type="checkbox"/> Water source – well, city, bottled or fluoridated <input type="checkbox"/> WIC
Development	<input type="checkbox"/> Puts 2-3 sentences together <input type="checkbox"/> Stands on 1 foot <input type="checkbox"/> Knows if boy or girl <input type="checkbox"/> Names objects <input type="checkbox"/> Imaginary play
Behavioral/Social	<input type="checkbox"/> Parental concerns <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Development <input type="checkbox"/> Plays with other children <input type="checkbox"/> Screen time < 2 hours <input type="checkbox"/> Manage anger <input type="checkbox"/> Reinforce good behavior
Social/Family History	<input type="checkbox"/> Changes since last visit <input type="checkbox"/> Parents working outside home <input type="checkbox"/> Child care type <input type="checkbox"/> Read, sing, play <input type="checkbox"/> Preschool <input type="checkbox"/> Family activities <input type="checkbox"/> Parent/Child interaction
Anticipatory Guidance Topics	<input type="checkbox"/> Car seat safety <input type="checkbox"/> Carbon monoxide detectors <input type="checkbox"/> Smoke detectors in home <input type="checkbox"/> Smoke-free environment <input type="checkbox"/> Child-proof home <input type="checkbox"/> Outdoor safety <input type="checkbox"/> Consistent routines <input type="checkbox"/> Sun exposure <input type="checkbox"/> Physical activity <input type="checkbox"/> Bike helmet <input type="checkbox"/> Supervise outside, street safety <input type="checkbox"/> Guns <input type="checkbox"/> Poisons <input type="checkbox"/> Limit TV to 1-2 hours/day
History	<input type="checkbox"/> Follow up previous visit <input type="checkbox"/> Medication review <input type="checkbox"/> Interval history <input type="checkbox"/> Special healthcare needs <input type="checkbox"/> Changes in family health <input type="checkbox"/> Past Medical History
Plan/Referrals	<input type="checkbox"/> Immunizations status <input type="checkbox"/> Influenza <input type="checkbox"/> Catch-up immunizations <input type="checkbox"/> Fluoride, if indicated <input type="checkbox"/> Dental referral



4-Year Assessment

Category	Assessment
Physical Exam	<input type="checkbox"/> Height/Weight/BMI Percentile <input type="checkbox"/> TPR - BP <input type="checkbox"/> General appearance <input type="checkbox"/> Head, fontanel <input type="checkbox"/> Neck <input type="checkbox"/> Eyes, red reflex, alignment <input type="checkbox"/> Ears, nose, mouth/throat <input type="checkbox"/> Dental – caries, staining, spots <input type="checkbox"/> Lungs <input type="checkbox"/> Heart <input type="checkbox"/> Abdomen <input type="checkbox"/> Femoral pulses <input type="checkbox"/> Genitalia (male-testes) <input type="checkbox"/> Spine <input type="checkbox"/> Extremities <input type="checkbox"/> Hips <input type="checkbox"/> Skin <input type="checkbox"/> Neuro
Risk Assessment/ Screening	<input type="checkbox"/> Hearing-Audiometry <input type="checkbox"/> Vision <input type="checkbox"/> Dyslipidemia risk assessment <input type="checkbox"/> Anemia risk screening <input type="checkbox"/> Lead risk screening <input type="checkbox"/> Tuberculosis risk screening <input type="checkbox"/> Assess: Language/ Speech/ Gross motor skills/Gait
Nutrition	<input type="checkbox"/> Fruits <input type="checkbox"/> Vegetables <input type="checkbox"/> Meat <input type="checkbox"/> Appetite <input type="checkbox"/> Dairy <input type="checkbox"/> Water source – well, city, bottled or fluoridated
Development	<input type="checkbox"/> Puts 2-3 sentences together <input type="checkbox"/> Hops on 1 foot <input type="checkbox"/> Knows name, age and gender <input type="checkbox"/> Names 4 colors <input type="checkbox"/> Dresses self <input type="checkbox"/> Brushes own teeth <input type="checkbox"/> Draws a person
Behavioral/Social	<input type="checkbox"/> Parental concerns <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Development <input type="checkbox"/> Plays with other children <input type="checkbox"/> Screen time < 2 hrs <input type="checkbox"/> Curiosity about sex
Social/Family History	<input type="checkbox"/> Changes since last visit <input type="checkbox"/> Parents working outside home <input type="checkbox"/> Preschool <input type="checkbox"/> Family activities <input type="checkbox"/> Parent/Child interaction <input type="checkbox"/> Helps at home
Anticipatory Guidance Topics	<input type="checkbox"/> Appropriate car restraints <input type="checkbox"/> Carbon monoxide detectors <input type="checkbox"/> Smoke detectors in home <input type="checkbox"/> Smoke-free environment <input type="checkbox"/> Safety rules with adults <input type="checkbox"/> Daily reading <input type="checkbox"/> Consistent routines <input type="checkbox"/> Sun exposure <input type="checkbox"/> Daily physical activity <input type="checkbox"/> Bike helmet <input type="checkbox"/> Outside supervision and street safety <input type="checkbox"/> Guns <input type="checkbox"/> Poisons <input type="checkbox"/> Limit TV to 1-2 hrs/day
History	<input type="checkbox"/> Follow up previous visit <input type="checkbox"/> Medication review <input type="checkbox"/> Interval history <input type="checkbox"/> Special healthcare needs <input type="checkbox"/> Changes in family health <input type="checkbox"/> Past Medical History
Plan/Referrals	<input type="checkbox"/> Immunizations status <input type="checkbox"/> DTaP, Influenza <input type="checkbox"/> Catch-up immunizations <input type="checkbox"/> Fluoride, if indicated <input type="checkbox"/> Dental home or referral <input type="checkbox"/> Lipid profile, if at risk <input type="checkbox"/> Audiometry



5- to 6-Year Assessment

Category	Assessment
Physical Exam	<input type="checkbox"/> Height/Weight/BMI Percentile <input type="checkbox"/> TPR – blood pressure <input type="checkbox"/> General appearance <input type="checkbox"/> Head, fontanel <input type="checkbox"/> Neck <input type="checkbox"/> Eyes <input type="checkbox"/> Ears, nose, mouth/throat <input type="checkbox"/> Dental – caries, staining, spots <input type="checkbox"/> Lungs <input type="checkbox"/> Heart <input type="checkbox"/> Abdomen <input type="checkbox"/> Femoral pulses <input type="checkbox"/> Genitalia (male-testes) <input type="checkbox"/> Spine <input type="checkbox"/> Musculoskeletal <input type="checkbox"/> Skin <input type="checkbox"/> Neuro
Risk Assessment/ Screening	<input type="checkbox"/> Hearing-Audiometry <input type="checkbox"/> Vision exam <input type="checkbox"/> Anemia risk screening <input type="checkbox"/> Lead risk screening <input type="checkbox"/> Dental assessment <input type="checkbox"/> Assess: Language/ Speech/ Gross motor skills/Gait
Nutrition	<input type="checkbox"/> Fruits <input type="checkbox"/> Vegetables <input type="checkbox"/> Meat <input type="checkbox"/> Appetite <input type="checkbox"/> Dairy <input type="checkbox"/> Water source – well, city, bottled or fluoridated
Development	<input type="checkbox"/> Good language skills <input type="checkbox"/> Speaks clearly <input type="checkbox"/> Balances on 1 foot <input type="checkbox"/> Ties a knot <input type="checkbox"/> Counts to 10 <input type="checkbox"/> Copies squares and triangles <input type="checkbox"/> Draws a person (6 parts)
Behavioral/Social	<input type="checkbox"/> Parental concerns <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Development/Learning <input type="checkbox"/> Attention <input type="checkbox"/> Social interaction <input type="checkbox"/> Cooperation/Oppositional <input type="checkbox"/> Sleep
Social/Family History	<input type="checkbox"/> Changes since last visit <input type="checkbox"/> Parents working outside home <input type="checkbox"/> After-school care/activities <input type="checkbox"/> Parent/Child/Sibling <input type="checkbox"/> Interaction <input type="checkbox"/> School readiness <input type="checkbox"/> Family time
Anticipatory Guidance Topics	<input type="checkbox"/> Appropriate booster/car restraints <input type="checkbox"/> Smoke/Carbon monoxide detectors <input type="checkbox"/> No smoking in home <input type="checkbox"/> Sexual safety <input type="checkbox"/> Swimming safety <input type="checkbox"/> Consistent routines <input type="checkbox"/> Sun exposure <input type="checkbox"/> Safety helmets <input type="checkbox"/> Street safety <input type="checkbox"/> Guns <input type="checkbox"/> Brushing/Flossing teeth <input type="checkbox"/> Limit TV <input type="checkbox"/> Healthy weight <input type="checkbox"/> Well-balanced diet, including breakfast <input type="checkbox"/> Daily physical activity <input type="checkbox"/> Bullying
History	<input type="checkbox"/> Follow up previous visit <input type="checkbox"/> Medication review <input type="checkbox"/> Interval history <input type="checkbox"/> Special healthcare needs <input type="checkbox"/> Changes in family health <input type="checkbox"/> Past Medical History
Plan/Referrals	<input type="checkbox"/> Immunizations status <input type="checkbox"/> DTaP, IPV, MMR, Varicella <input type="checkbox"/> Influenza <input type="checkbox"/> Catch-up immunizations <input type="checkbox"/> Fluoride, if indicated <input type="checkbox"/> Dental referral <input type="checkbox"/> Audiometry



7- to 8-Year Assessment

Category	Assessment
Physical Exam	<input type="checkbox"/> Height/Weight/BMI Percentile <input type="checkbox"/> TPR – BP <input type="checkbox"/> General appearance <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Eyes, red reflex, alignment <input type="checkbox"/> Ears, nose, mouth/throat <input type="checkbox"/> Dental – caries, gingival <input type="checkbox"/> Lungs <input type="checkbox"/> Heart <input type="checkbox"/> Abdomen <input type="checkbox"/> Femoral pulses <input type="checkbox"/> Breasts/Genitalia <input type="checkbox"/> Sexual maturity <input type="checkbox"/> Spine <input type="checkbox"/> Musculoskeletal <input type="checkbox"/> Skin <input type="checkbox"/> Neuro
Risk Assessment/ Screening	<input type="checkbox"/> Hearing <input type="checkbox"/> Vision exam <input type="checkbox"/> Anemia risk screening <input type="checkbox"/> Tuberculosis risk assessment <input type="checkbox"/> Dental assessment <input type="checkbox"/> Alcohol/Drugs assessment
Nutrition	<input type="checkbox"/> Fruits <input type="checkbox"/> Vegetables <input type="checkbox"/> Meat <input type="checkbox"/> Appetite <input type="checkbox"/> Dairy <input type="checkbox"/> Eats breakfast <input type="checkbox"/> Water source – well, city, bottled or fluoridated
Development	<input type="checkbox"/> Good hand-eye coordination <input type="checkbox"/> Enjoys hobbies and collecting <input type="checkbox"/> Uses reflective thinking <input type="checkbox"/> May experience guilt/shame
Behavioral/Social	<input type="checkbox"/> Parental concerns <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Development/learning <input type="checkbox"/> Participates in after-school activities <input type="checkbox"/> Doing well in school <input type="checkbox"/> Homework <input type="checkbox"/> Sleep
Social/Family History	<input type="checkbox"/> Changes since last visit <input type="checkbox"/> Parents working outside home <input type="checkbox"/> After-school care/activities <input type="checkbox"/> Parent/child/sibling interaction <input type="checkbox"/> Parent/Teacher concerns <input type="checkbox"/> Eats meals as a family
Anticipatory Guidance Topics	<input type="checkbox"/> Appropriate booster/Car restraints <input type="checkbox"/> Smoke/Carbon monoxide detectors <input type="checkbox"/> No smoking in home <input type="checkbox"/> Sexual safety <input type="checkbox"/> Swimming safety <input type="checkbox"/> Consistent routines <input type="checkbox"/> Sun exposure <input type="checkbox"/> Safety helmets and pads <input type="checkbox"/> Street safety <input type="checkbox"/> Guns <input type="checkbox"/> Brushing/Flossing teeth <input type="checkbox"/> Limit TV and screen time <input type="checkbox"/> Well-balanced diet, including breakfast <input type="checkbox"/> Healthy weight <input type="checkbox"/> Daily physical activity <input type="checkbox"/> Bullying
History	<input type="checkbox"/> Follow up previous visit <input type="checkbox"/> Medication review <input type="checkbox"/> Interval history <input type="checkbox"/> Special healthcare needs <input type="checkbox"/> Changes in family health <input type="checkbox"/> Past Medical History
Plan/Referrals	<input type="checkbox"/> Immunizations status <input type="checkbox"/> Influenza <input type="checkbox"/> Catch-up immunizations <input type="checkbox"/> Fluoride, if indicated



9- to 10-Year Assessment

Category	Assessment
Physical Exam	<input type="checkbox"/> Height/Weight/BMI Percentile <input type="checkbox"/> TPR – BP <input type="checkbox"/> General appearance <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Eyes, red reflex, alignment <input type="checkbox"/> Ears, nose, mouth/throat <input type="checkbox"/> Dental – caries, gingival <input type="checkbox"/> Lungs <input type="checkbox"/> Heart <input type="checkbox"/> Abdomen <input type="checkbox"/> Femoral pulses <input type="checkbox"/> Umbilical cord <input type="checkbox"/> Breasts/Genitalia <input type="checkbox"/> Sexual maturity <input type="checkbox"/> Spine <input type="checkbox"/> Musculoskeletal <input type="checkbox"/> Skin <input type="checkbox"/> Neuro
Risk Assessment/ Screening	<input type="checkbox"/> Hearing <input type="checkbox"/> Vision exam <input type="checkbox"/> Anemia risk screening <input type="checkbox"/> Tuberculosis risk assessment <input type="checkbox"/> Dental assessment <input type="checkbox"/> Alcohol/Drugs assessment
Nutrition	<input type="checkbox"/> Fruits <input type="checkbox"/> Vegetables <input type="checkbox"/> Meat <input type="checkbox"/> Appetite <input type="checkbox"/> Dairy <input type="checkbox"/> Eats breakfast <input type="checkbox"/> Water source – well, city, bottled or fluoridated
Development	<input type="checkbox"/> Rough and tumble play <input type="checkbox"/> Enjoys team games <input type="checkbox"/> Likes complex crafts and tasks <input type="checkbox"/> Ability to learn and apply skills <input type="checkbox"/> Capable of longer interest <input type="checkbox"/> More abstract reasoning
Behavioral/Social	<input type="checkbox"/> Parental concerns <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Development/learning <input type="checkbox"/> Self-control <input type="checkbox"/> Sense of accomplishment <input type="checkbox"/> Competitive
Social/Family History	<input type="checkbox"/> Changes since last visit <input type="checkbox"/> Parents working outside home <input type="checkbox"/> After-school care/activities <input type="checkbox"/> Parent/Teacher concerns <input type="checkbox"/> More independent <input type="checkbox"/> Very conscious of fairness
Anticipatory Guidance Topics	<input type="checkbox"/> Appropriate booster/car restraints <input type="checkbox"/> Smoke/Carbon monoxide detectors <input type="checkbox"/> No smoking in home <input type="checkbox"/> Sexual safety <input type="checkbox"/> Swimming safety <input type="checkbox"/> Consistent routines <input type="checkbox"/> Sun exposure <input type="checkbox"/> Safety helmets and pads <input type="checkbox"/> Street safety <input type="checkbox"/> Guns <input type="checkbox"/> Brushing/Flossing teeth <input type="checkbox"/> Limit TV and screen time <input type="checkbox"/> Well-balanced diet, including breakfast <input type="checkbox"/> Healthy weight <input type="checkbox"/> Daily physical activity <input type="checkbox"/> Bullying
History	<input type="checkbox"/> Follow up previous visit <input type="checkbox"/> Medication review <input type="checkbox"/> Interval history <input type="checkbox"/> Special healthcare needs <input type="checkbox"/> Changes in family health <input type="checkbox"/> Past Medical History
Plan/Referrals	<input type="checkbox"/> Immunizations status <input type="checkbox"/> Influenza <input type="checkbox"/> Catch-up immunizations <input type="checkbox"/> Fluoride, if indicated



11- to 14-Year Assessment

Category	Assessment
Physical Exam	<input type="checkbox"/> Height/Weight/BMI Percentile <input type="checkbox"/> TPR – blood pressure <input type="checkbox"/> General appearance <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Eyes, red reflex, alignment <input type="checkbox"/> Ears, nose, mouth/throat <input type="checkbox"/> Dental – caries, gingival <input type="checkbox"/> Lungs <input type="checkbox"/> Heart <input type="checkbox"/> Abdomen <input type="checkbox"/> Femoral pulses <input type="checkbox"/> Umbilical cord <input type="checkbox"/> Breasts/Genitalia <input type="checkbox"/> Sexual maturity <input type="checkbox"/> Spine <input type="checkbox"/> Musculoskeletal <input type="checkbox"/> Skin <input type="checkbox"/> Neuro
Risk Assessment/ Screening	<input type="checkbox"/> Hearing <input type="checkbox"/> Vision exam <input type="checkbox"/> Anemia risk screening <input type="checkbox"/> Tuberculosis risk assessment <input type="checkbox"/> Dental assessment <input type="checkbox"/> Alcohol/Drugs assessment <input type="checkbox"/> Cervical dysplasia risk screening <input type="checkbox"/> STI risk screening
Nutrition	<input type="checkbox"/> Fruits <input type="checkbox"/> Vegetables <input type="checkbox"/> Meat <input type="checkbox"/> Appetite <input type="checkbox"/> Dairy – including low-fat options <input type="checkbox"/> Eats breakfast <input type="checkbox"/> Water source – well, city, bottled or fluoridated
Development	<input type="checkbox"/> Pubic and underarm hair growth <input type="checkbox"/> Girls: Breast development/Menarche/Rapid growth spurt <input type="checkbox"/> Boys: Voice changes/Genital growth/Nocturnal emissions <input type="checkbox"/> Understands abstract ideas
Behavioral/Social	<input type="checkbox"/> Parental concerns <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Development/Learning <input type="checkbox"/> Develop moral philosophies <input type="checkbox"/> Self-esteem <input type="checkbox"/> Sexual activity
Social/Family History	<input type="checkbox"/> Changes since last visit <input type="checkbox"/> After-school activities <input type="checkbox"/> Family relationships
Anticipatory Guidance Topics	<input type="checkbox"/> Seat belts <input type="checkbox"/> Smoke/Carbon monoxide detectors <input type="checkbox"/> No smoking in home <input type="checkbox"/> Sexual safety <input type="checkbox"/> How to prevent pregnancy, STDs, HIV <input type="checkbox"/> Sun exposure <input type="checkbox"/> Sports safety – helmets, water <input type="checkbox"/> Street safety <input type="checkbox"/> Guns <input type="checkbox"/> Oral hygiene <input type="checkbox"/> Limit TV and screen time <input type="checkbox"/> Well-balanced diet, including breakfast <input type="checkbox"/> Healthy weight <input type="checkbox"/> Daily physical activity <input type="checkbox"/> Bullying <input type="checkbox"/> Adequate sleep <input type="checkbox"/> Stress management <input type="checkbox"/> Anger management
History	<input type="checkbox"/> Follow up previous visit <input type="checkbox"/> Medication review <input type="checkbox"/> Interval history <input type="checkbox"/> Special healthcare needs <input type="checkbox"/> Changes in family health <input type="checkbox"/> Past Medical History
Plan/Referrals	<input type="checkbox"/> Immunizations status <input type="checkbox"/> Influenza <input type="checkbox"/> Catch-up immunizations <input type="checkbox"/> Fluoride, if indicated



15- to 17-Year Assessment

Category	Assessment
Physical Exam	<input type="checkbox"/> Height/Weight/BMI Percentile <input type="checkbox"/> TPR – BP <input type="checkbox"/> General appearance <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Eyes <input type="checkbox"/> Ears, nose, mouth/throat <input type="checkbox"/> Dental – caries, gingival <input type="checkbox"/> Lungs <input type="checkbox"/> Heart <input type="checkbox"/> Abdomen <input type="checkbox"/> Femoral pulses <input type="checkbox"/> Breasts/Genitalia <input type="checkbox"/> Sexual maturity <input type="checkbox"/> Spine <input type="checkbox"/> Musculoskeletal <input type="checkbox"/> Skin <input type="checkbox"/> Neuro
Risk Assessment/ Screening	<input type="checkbox"/> Hearing <input type="checkbox"/> Vision exam <input type="checkbox"/> Anemia risk screening <input type="checkbox"/> Tuberculosis risk assessment <input type="checkbox"/> Dental assessment <input type="checkbox"/> Alcohol/Drugs assessment <input type="checkbox"/> Cervical dysplasia risk screening <input type="checkbox"/> STI risk screening
Nutrition	<input type="checkbox"/> Fruits <input type="checkbox"/> Vegetables <input type="checkbox"/> Meat <input type="checkbox"/> Appetite <input type="checkbox"/> Low-fat dairy <input type="checkbox"/> Eats breakfast <input type="checkbox"/> Water source – well, city, bottled or fluoridated
Development	<input type="checkbox"/> Girls – full physical development <input type="checkbox"/> Boys – voice lowers, facial hair, muscle gain and height <input type="checkbox"/> Interest in new music, fashion <input type="checkbox"/> Solve problems <input type="checkbox"/> More aware – sexual orientation <input type="checkbox"/> Plans for future work/education
Behavioral/Social	<input type="checkbox"/> Parental concerns <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Development/Learning <input type="checkbox"/> Challenge school/parents rules <input type="checkbox"/> Dissatisfied with appearance
Social/Family History	<input type="checkbox"/> Changes since last visit <input type="checkbox"/> More time with friends or alone <input type="checkbox"/> Begins interest in religion, politics, causes <input type="checkbox"/> Seeks more control over life <input type="checkbox"/> Positive family relationships
Anticipatory Guidance Topics	<input type="checkbox"/> Seat belts <input type="checkbox"/> Smoke/Carbon monoxide detectors <input type="checkbox"/> No smoking in home <input type="checkbox"/> Sexual safety <input type="checkbox"/> How to prevent pregnancy, STDs, HIV <input type="checkbox"/> Sun exposure <input type="checkbox"/> Sports safety – helmets, water <input type="checkbox"/> Alcohol <input type="checkbox"/> Tobacco <input type="checkbox"/> Drugs <input type="checkbox"/> Oral hygiene <input type="checkbox"/> Limit TV and screen time <input type="checkbox"/> Daily activity <input type="checkbox"/> Well-balanced diet, including breakfast <input type="checkbox"/> Healthy weight <input type="checkbox"/> Anger management
History	<input type="checkbox"/> Follow up previous visit <input type="checkbox"/> Medication review <input type="checkbox"/> Interval history <input type="checkbox"/> Special healthcare needs <input type="checkbox"/> Changes in family health <input type="checkbox"/> Past Medical History
Plan/Referrals	<input type="checkbox"/> Immunizations status <input type="checkbox"/> Influenza <input type="checkbox"/> Catch-up immunizations <input type="checkbox"/> Fluoride, if indicated



18- to 21-Year Assessment

Category	Assessment
Physical Exam	<input type="checkbox"/> Height/Weight/BMI Percentile <input type="checkbox"/> TPR – BP <input type="checkbox"/> General appearance <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Eyes <input type="checkbox"/> Ears, nose, mouth/throat <input type="checkbox"/> Dental – caries, gingival <input type="checkbox"/> Lungs <input type="checkbox"/> Heart <input type="checkbox"/> Abdomen <input type="checkbox"/> Femoral pulses <input type="checkbox"/> Breasts/Genitalia <input type="checkbox"/> Sexual maturity <input type="checkbox"/> Spine <input type="checkbox"/> Musculoskeletal <input type="checkbox"/> Skin <input type="checkbox"/> Neuro
Risk Assessment/ Screening	<input type="checkbox"/> Hearing <input type="checkbox"/> Vision exam <input type="checkbox"/> Anemia risk screening <input type="checkbox"/> Tuberculosis risk assessment <input type="checkbox"/> Dental assessment <input type="checkbox"/> Alcohol/Drugs assessment <input type="checkbox"/> Cervical dysplasia risk screening <input type="checkbox"/> STI risk screening
Nutrition	<input type="checkbox"/> Fruits <input type="checkbox"/> Vegetables <input type="checkbox"/> Meat <input type="checkbox"/> Appetite <input type="checkbox"/> Low-fat dairy <input type="checkbox"/> Eats breakfast <input type="checkbox"/> Water source – well, city, bottled or fluoridated
Development	<input type="checkbox"/> Girls – full physical development <input type="checkbox"/> Boys – may continue to gain muscle and height <input type="checkbox"/> Sense of self <input type="checkbox"/> Self-reliant <input type="checkbox"/> Makes own decisions <input type="checkbox"/> Sets goals <input type="checkbox"/> Plans for future work/education
Behavioral/Social	<input type="checkbox"/> Responsibility for actions <input type="checkbox"/> Coping skills
Social/Family History	<input type="checkbox"/> Changes since last visit <input type="checkbox"/> Concern about relationships <input type="checkbox"/> Living on their own
Anticipatory Guidance Topics	<input type="checkbox"/> Seat belts <input type="checkbox"/> Smoke/Carbon monoxide detectors <input type="checkbox"/> Work stress <input type="checkbox"/> Safe sex <input type="checkbox"/> How to prevent pregnancy, STDs, HIV <input type="checkbox"/> Sun exposure <input type="checkbox"/> Sports safety <input type="checkbox"/> Alcohol <input type="checkbox"/> Tobacco <input type="checkbox"/> Drugs <input type="checkbox"/> Oral hygiene <input type="checkbox"/> No texting while driving <input type="checkbox"/> Well-balanced diet, including breakfast <input type="checkbox"/> Healthy weight <input type="checkbox"/> Daily physical activity <input type="checkbox"/> Stress management
History	<input type="checkbox"/> Follow up previous visit <input type="checkbox"/> Medication review <input type="checkbox"/> Interval history <input type="checkbox"/> Special healthcare needs <input type="checkbox"/> Changes in family health <input type="checkbox"/> Past Medical History
Plan/Referrals	<input type="checkbox"/> Immunizations status <input type="checkbox"/> Influenza <input type="checkbox"/> Catch-up immunizations <input type="checkbox"/> Fluoride, if indicated <input type="checkbox"/> Lipid profile, if at risk <input type="checkbox"/> TB test, if at risk

Please refer to available state forms or resources below for forms and information on use.

Please note: This document contains general screening, guidelines and topics to assist with examination and documentation of well-child exams.

For more detailed information, risk assessments, forms and information contained therein, please go to:

- American Academy of Pediatrics - www.aap.org
- The Advisory Committee on Immunization Practices - www.cdc.gov/vaccines/acip/recs/index.html
- The American Academy of Family Physicians - www.aafp.org



www.wellcare.com/Georgia