

**TUSCARAWAS COUNTY JOB & FAMILY SERVICES  
HEALTHCHEK (EPSDT) EXAM CHECKLIST**

NAME \_\_\_\_\_ DOB \_\_\_\_\_ DATE \_\_\_\_\_

1. **HEALTHCHEK (EPSDT) EXAM** Components (A) through (I) must be performed as part of every initial or periodic HEALTHCHEK (EPSDT) examination. Laboratory services (J) must be completed if medically indicated.

**A. Comprehensive Health and Development History**

- Allergies \_\_\_\_\_
- Chief Complaint, Current Complaints/Concerns \_\_\_\_\_
- Medical History \_\_\_\_\_
- Family History of Illnesses, Diseases, Allergies \_\_\_\_\_
- Current Medications & Adverse Effects to Medication \_\_\_\_\_
- Notation of sexual activity and contraceptive methods of adolescents \_\_\_\_\_

**B. Comprehensive Unclothed Physical**

- HEIGHT \_\_\_\_\_ PERCENTILE \_\_\_\_\_ WEIGHT \_\_\_\_\_ PERCENTILE \_\_\_\_\_
- Head circumference (as age appropriate) \_\_\_\_\_
- General appearance \_\_\_\_\_
- Blood Pressure (as age appropriate) \_\_\_\_\_
- Examination of respiratory and cardiovascular system: Respirations: \_\_\_\_\_ Pulse: \_\_\_\_\_  
Cardiovascular, Gastrointestinal, Reproductive, Eyes: \_\_\_\_\_ Ears: \_\_\_\_\_  
Musculoskeletal, Neurological Nose: \_\_\_\_\_ Throat: \_\_\_\_\_
- Pelvic examination, if medically indicated \_\_\_\_\_
- Testicular exam, if medically indicated, & instruction in self-examination \_\_\_\_\_
- Breast Inspection & Palpation, and instruction in breast self-examination \_\_\_\_\_

**C. Developmental Assessment,**

| Age<br>Appropriate       | Developmentally<br>Delayed |                                  |       |
|--------------------------|----------------------------|----------------------------------|-------|
| <input type="checkbox"/> | <input type="checkbox"/>   | Gross and fine motor development | _____ |
| <input type="checkbox"/> | <input type="checkbox"/>   | Communication skills             | _____ |
| <input type="checkbox"/> | <input type="checkbox"/>   | Self-help skills                 | _____ |
| <input type="checkbox"/> | <input type="checkbox"/>   | Social-emotional development     | _____ |
| <input type="checkbox"/> | <input type="checkbox"/>   | Cognitive skills                 | _____ |

**D. Nutritional Assessment**

- Dietary History \_\_\_\_\_

**E. Vision Assessment**

- Internal ophthalmoscopy (children ages birth–3 years) and external (gross) observation \_\_\_\_\_
- External observation, internal ophthalmoscopy, visual acuity testing, and complete ocular muscle balance test (children ages 3-20 years administered at distance and near) \_\_\_\_\_
- Stereopsis test \_\_\_\_\_

**F. Hearing Assessment**

- Manually-administered individual pure-tone air conduction screenings (age 3 and above), if available \_\_\_\_\_
- Observation by gross exam children ages birth – 3 years and 3 years – 20 years (if pure-tone available) \_\_\_\_\_
- Other: \_\_\_\_\_

--over--

**G. Dental Assessment**

- Growth and Development assessment of dento-facial structure (birth-2) \_\_\_\_\_
- Oral inspection for dental caries (birth-2) \_\_\_\_\_
- Referral of children with suspected problems to a dentist \_\_\_\_\_
- Parent instructed to make dental appointment (recommended for children over 2 years of age, required for those 3 years of age and older) \_\_\_\_\_

**H. Immunization Assessment**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> IPV @ 2 mo _____       | <input type="checkbox"/> DTaP @ 2 mo _____          | <input type="checkbox"/> Hep B @ Birth _____                |
| <input type="checkbox"/> IPV @ 4 mo _____       | <input type="checkbox"/> DTaP @ 4 mo _____          | <input type="checkbox"/> Hep B @ 1-2 mo _____               |
| <input type="checkbox"/> IPV @ 6-18 mo _____    | <input type="checkbox"/> DTaP @ 6 mo _____          | <input type="checkbox"/> Hep B @ 6-18 mo _____              |
| <input type="checkbox"/> IPV @ 4-6 yr _____     | <input type="checkbox"/> DTaP @ 15-18 mo _____      | <input type="checkbox"/> PCV 13 @ 2 mo _____                |
| <input type="checkbox"/> MMR @ 12-15 mo _____   | <input type="checkbox"/> DTaP @ 4-6 yr _____        | <input type="checkbox"/> PCV 13 @ 4 mo _____                |
| <input type="checkbox"/> MMR @ 4-6 yr _____     | <input type="checkbox"/> Tdap @ 11-12 yr _____      | <input type="checkbox"/> PCV 13 @ 6 mo _____                |
| <input type="checkbox"/> Meningococcal _____    | <input type="checkbox"/> Varicella @ 12-15 mo _____ | <input type="checkbox"/> PCV 13 @ 12-15 mo _____            |
| <input type="checkbox"/> Rotavirus @ 2 mo _____ | <input type="checkbox"/> Varicella @ 4-6 yr _____   | <input type="checkbox"/> HPV2/HPV4 @ 11-12 yr _____         |
| <input type="checkbox"/> Rotavirus @ 4 mo _____ | <input type="checkbox"/> Hep A @ 12-23 mo _____     | <input type="checkbox"/> Influenza @ 6-23 mo, 2 doses _____ |
| <input type="checkbox"/> Rotavirus @ 6 mo _____ |   | <input type="checkbox"/> Influenza @ 2-18 yr, annual _____  |

**Haemophilus Influenza B (HIB)** Recommended by the American Academy of Pediatrics (AAP) (11/90)

- Hib-Conjugate @ 2 mo \_\_\_\_\_  Hib-conjugate @ 4 mo \_\_\_\_\_
- Hib-Conjugate @ 6 mo \_\_\_\_\_  Hib-Conjugate @ 12-15 mo \_\_\_\_\_

**I. Health Education**

- Patient education such as child's development, accident and disease prevention, and benefits of healthy lifestyles, breast exam, immunizations, weight management, smoking cessation, alcohol/drug dependency \_\_\_\_\_
- Discuss results of HEALTHCHEK exam \_\_\_\_\_
- Counsel about baby bottle tooth decay, if applicable, and fluoride treatment \_\_\_\_\_

**J. Laboratory Services**

1. Lead toxicity screening must be done at any age, if indicated, and required annually between the first birthday and the day before the fourth birthday:
  - 1 year                       2 years                       3 years                       Other
 Every child receiving an initial HEALTHCHEK (EPSDT) exam between the fourth birthday and the day before the sixth birthday must be tested.
2. Hemoglobin and/or Hematocrit: Recommended on all low birth weight babies during first six (6) months of life, children one (1) year of age and once during adolescence:
  - Hgb     HCT
3. Sickle cell test and other hemoglobinopathies:
  - Was child born in Ohio (after March 1, 1990)?
  - If no, please test and/or list results \_\_\_\_\_
4.  Pap Smears for age-appropriate females                      Results: \_\_\_\_\_  
 Tests for sexually-transmitted diseases if medically indicated for age-appropriate females/males                      Results: \_\_\_\_\_
5. Tuberculin test:
  - Tuberculin Test      Results: \_\_\_\_\_
6.  Other: \_\_\_\_\_

**K. Follow-up or Referable Condition**

Diagnosis: \_\_\_\_\_  
 Referred to: \_\_\_\_\_ Date of Appointment: \_\_\_\_\_

|   |
|---|
| PHYSICIAN'S SIGNATURE:                    |
| PLEASE PRINT NAME, ADDRESS, PHONE NUMBER: |

RETURN TO TCJFS  
 389 – 16<sup>th</sup> Street, SW  
 New Philadelphia, Ohio 44663  
 or FAX TO:  
 330-308-7790