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 Appropriate	Developmentally Delayed	
☐	☐	Gross and fine motor development _____
☐	☐	Communication skills _____
☐	☐	Self-help skills _____
☐	☐	Social-emotional development _____
☐	☐	Cognitive skills _____

D. **Nutritional Assessment**

- ☐ Dietary History _____

E. **Vision Assessment**

- ☐ Internal opthalmoscopy (children ages birth–3 years) and external (gross) observation _____
- ☐ External observation, internal opthalmoscopy, 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**

☐ IPV @ 2 mo	_____	☐ DTaP @ 2 mo	_____	☐ Hep B @ Birth	_____
☐ IPV @ 4 mo	_____	☐ DTaP @ 4 mo	_____	☐ Hep B @ 1-2 mo	_____
☐ IPV @ 6-18 mo	_____	☐ DTaP @ 6 mo	_____	☐ Hep B @ 6-18 mo	_____
☐ IPV @ 4-6 yr	_____	☐ DTaP @ 15-18 mo	_____	☐ PCV 13 @ 2 mo	_____
☐ MMR @ 12-15 mo	_____	☐ DTaP @ 4-6 yr	_____	☐ PCV 13 @ 4 mo	_____
☐ MMR @ 4-6 yr	_____	☐ Tdap @ 11-12 yr	_____	☐ PCV 13 @ 6 mo	_____
☐ Meningococcal	_____	☐ Varicella @ 12-15 mo	_____	☐ PCV 13 @ 12-15 mo	_____
☐ Rotavirus @ 2 mo	_____	☐ Varicella @ 4-6 yr	_____	☐ HPV2/HPV4 @ 11-12 yr	_____
☐ Rotavirus @ 4 mo	_____	☐ Hep A @ 12-23 mo	_____	☐ Influenza @ 6-23 mo, 2 doses	_____
☐ Rotavirus @ 6 mo	_____			☐ 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 – 16th Street, SW
New Philadelphia, Ohio 44663
or FAX TO:
330-308-7790