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

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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 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
☐ 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 ☐ HPV2/HPV4 @ 11-12 yr
☐ Rotavirus @ 2 mo  ☐ Varicella @ 4-6 yr  ☐ Influenza @ 2-18 yr, annual
☐ Rotavirus @ 4 mo  ☐ Hep A @ 12-23 mo  ☐ Meningococcal
☐ Rotavirus @ 6 mo  ☐ Influenza @ 12-23 mo ☐ Varicella @ 12-15 mo

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
    ☐ Tests for sexually-transmitted diseases if medically indicated for age-appropriate females/males

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: