HealthCheck Health History Form — 0-6 Years

Patient Name: ______________________ **Date of Birth:** ______________ **Age:** ________

Your Name: ______________________ **Relationship to child:** ______________________

Child's Health History

Pregnancy and Birth

Medical problems during pregnancy? ______________________

In utero drug exposure? ______________________

Where was the child born? ______________________

Delivered by: ☐ Vaginal ☐ C-section

Why C-section? ______________________

Birth Weight: ____________ Birth Length: ____________

☐ Full Term (≥ 37 weeks gestation)

☐ Preterm (≤ 36 weeks gestation)

☐ NICU stay: ______________ weeks

Other problems in the newborn period? ______________________

Infancy and Childhood

Has your child ever been treated for or diagnosed with:

☐ Asthma or wheezing ______________________

☐ Pneumonia ______________________

☐ Lung problems ______________________

☐ Heart murmur ______________________

☐ Anemia ______________________

☐ Recurrent ear infections ______________________

☐ Hearing problems ______________________

☐ Vision or eye problems ______________________

☐ Urinary tract infections ______________________

☐ Stomach or digestive problems ______________________

☐ Seasonal allergies or eczema ______________________

☐ Seizures ______________________

☐ Broken bone(s) ______________________

☐ Learning disability ______________________

☐ Depression/anxiety ______________________

☐ ADD/ADHD______________________

☐ Other chronic medical problems ______________________

Has your child ever been hospitalized?

☐ No ☐ Yes Why? ______________________

Previous surgeries: ______________________

Please list any specialists your child is currently seeing and reason:

____

Developmental

Do you have concerns about any of the following:

☐ Problems with sleeping or nightmares

☐ The way your child uses his/her arms, fingers or legs

☐ Speech problems

☐ Bad temper/breath holding/ jealousy

☐ Nail biting/thumb sucking

☐ Vision (Are you concerned about your child's vision?)

☐ Hearing (Are you concerned about your child's hearing?)

Exposure/Habits

Any concerns about lead exposure (old home, plumbing, peeling paint)? ☐ Yes ☐ No

Do any household members smoke? ☐ Yes ☐ No

TV hours per day ______________________

Computer hours per day ______________________

Video games – hours per day ______________________

Is violence at home a concern? ☐ Yes ☐ No

Child's Health History

Medications

Current medications and dose: ______________________

Vitamins: ______________________

Herbs/home remedies: ______________________

Over the counter: ______________________

Allergies/reactions to medications or vaccines: ______________________

Nutrition and Feeding

☐ Has your child had any feeding/dietary problems? ______________________

☐ Unexplained weight gain

☐ Unexplained weight loss

☐ Food allergies: ______________________

☐ Participates in WIC

Dental

☐ Problems with teeth or gums

☐ Bad breath

Has your child been seen by a dentist? ☐ Yes ☐ No

If so, date of last exam: ______________________

Why did he/she see the dentist? ______________________

Water source: ☐ City ☐ Well

Family Medical History

Do any family members have any of the following conditions?

Condition	Mother	Father	Sibling	Grandparent
Asthma	☐	☐	☐	☐
Anemia	☐	☐	☐	☐
Blood disorder	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐
Heart attack	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
Depression/anxiety	☐	☐	☐	☐
Drug and alchol use	☐	☐	☐	☐

Other ______________________

Other Concerns:

Reviewed by: ______________________

Date: ______________________

HealthCheck Health History Form 7-20 Years

Patient Name: ______________________ **Date of Birth:** ____________ **Age:** ________

Your Name: ______________________ **Relationship to child:** ____________

Child's Health History

Childhood

Has your child ever been treated for or diagnosed with:

☐ Asthma or wheezing ____________
☐ Pneumonia ____________
☐ Lung problems ____________
☐ Heart murmur ____________
☐ Anemia ____________
☐ Recurrent ear infections ____________
☐ Hearing problems ____________
☐ Vision or eye problems ____________
☐ Urinary tract infections ____________
☐ Stomach or digestive problems ____________
☐ Seasonal allergies or eczema ____________
☐ Seizures ____________
☐ Broken bone(s) ____________
☐ Learning disability ____________
____
☐ Depression/ anxiety ____________
☐ ADD/ADHD ____________
☐ Other chronic medical problems ____________
____

Has your child ever been hospitalized?
☐ No ☐ Yes Why? ____________
Previous surgeries: ____________
Please list any specialists your child is currently seeing and reason:
____
____

Developmental/Behavior

Do you have concerns about any of the following:

☐ Problems with sleeping or nightmares
☐ The way your child uses his/her arms, fingers or legs
☐ Speech problems
☐ Bad temper/breath holding/jealousy
☐ Nail biting/thumb sucking
☐ Bedwetting (after 6 years)
☐ Vision (Are you concerned about your child's vision?)
☐ Hearing (Are you concerned about your child's hearing?)

Does your child have problems with:

☐ School attendance
☐ Getting along with other children including siblings
☐ Getting along with parents or other adults
☐ Threaten to harm self, others or animals
☐ Sexual acting out
☐ Destroying property
☐ Drug use, alcohol use or smoking

Puberty

Concerns about:

☐ Body changes
☐ Sexual activity
☐ Sexually transmitted infection
☐ Discharge: vaginal or penis
☐ Contraception

For Girls:
Age of first menstrual period? ____________

Child's Health History

Medications

Current medications and dose: ____________
____
____
Vitamins: ____________
Herbs/home remedies: ____________
Over the counter: ____________
Allergies/reactions to medications or vaccines: ____________
____
____

Nutrition

☐ Has your child had any dietary problems? ____________
____
☐ Unexplained weight gain
☐ Unexplained weight loss
☐ Food allergies: ____________

Dental

☐ Problems with teeth or gums
☐ Bad breath
Has your child been seen by a dentist? ☐ Yes ☐ No
If so, date of last exam: ____________
Why did he/she see the dentist? ____________

Exposure/Habits

Any concerns about lead exposure (old home, plumbing, peeling paint)? ☐ Yes ☐ No
Do any household members smoke? ☐ Yes ☐ No
TV hours per day ____________
Computer hours per day ____________
Video games – hours per day ____________
Is violence at home a concern? ☐ Yes ☐ No

Family Medical History

Do any family members have any of the following conditions?

Condition	Mother	Father	Sibling	Grandparent
Asthma	☐	☐	☐	☐
Anemia	☐	☐	☐	☐
Blood disorder	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐
Heart attack	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐
Seizures	☐	☐	☐	☐
Depression/anxiety	☐	☐	☐	☐
Drug and alchol use	☐	☐	☐	☐

Other ____________
____

Other Concerns:

Reviewed by: ____________
Date: ____________

West Virginia Department of Health and Human Resources
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
HealthCheck Program Preventive Health Screen

1 Day-4 Weeks Form

Name_______________ DOB_______________ Age__________ Sex: M F Wt________ Ht________ HC________ Temp________ Pulse___________ Screen Date_________________

Allergies: □ NKDA ______________________________ Current Meds: □ None ______________________________

Accompanied by: □ Parent □ Grandparent □ Foster parent/organization □ Other ______________________________

History: □ No change □ Initial screen
Birth weight____________ Discharge weight__________________
Newborn metabolic screen □ **NL**
Newborn Critical Congenital Heart Disease Pulse Oximetry ______
Newborn hearing screen □ Pass □ Fail
Concerns and questions:

Follow up on previous concerns:

Social/Family History: *✓ Check those that apply*
Adjustment to new child:

Reaction of sibling(s) to new child: □ NA

Caretaker(s) working outside home? □ Yes □ No
Child care plans:

Other changes since last visit:

Current Health Indicators: *✓ Check those that apply*
□ No change
Changes since last visit:

□ GROWTH PLOTTED ON GROWTH CHART
□ Normal elimination
□ Normal sleep patterns
□ Sleeps 3 or 4 hours at a time; can stay awake for 1 hour or longer
Comments:

Nutrition: □ Breast feeding; Frequency ________________
□ Bottle feeding; Amount_________ Frequency___________
□ Formula ________________________________
Comments:

□ Passive Smoking Risk □ Yes □ No

Tuberculosis Risk *(at 4 weeks)*: □ Low risk □ High risk
□ Increased risk of exposure d/t Contacts/Travel/Immigration
□ Radiographic or clinical findings suggestive of TB

□ **Developmental Surveillance:** *✓ Check those that apply*
Gross Motor:
□ Raises head slightly in prone position
□ Flexed posture
□ Moves all extremities

Sensory:
□ Blinks in reaction to bright light
□ Follows with eyes, fixates on human face
□ Responds to sound
□ Can be consoled when crying
Comments:

Appropriate Behavior □ Yes □ No

Do you think your child sees OK? □ Yes □ No

Do you think your child hears OK? □ Yes □ No

Oral Health Screen

Water source:
□ Public
□ Well □ Tested

□ Current oral health problems:

Physical Examination: *✓= Normal limits*

□ General Appearance		□ Skin
□ Neurological		□ Reflexes
□ Head	□ Fontanelles	□ Neck
□ Eyes	□ Red Reflex	
□ Oral Cavity/Throat		
□ Ears	□ Nose	□ Pulses
□ Lungs	□ Heart	□ Genitalia
□ Abdomen	□ Hips	□ Extremities
□ Back		

Abnormal Findings and Comments:
Jaundice □ Yes □ No
Possible Signs of Abuse □ Yes □ No

Health Education/Anticipatory Guidance:
□ Discussed □ Handout(s) given
Healthy and safe habits: nutrition, sleep, oral/dental care, injury and illness prevention, infant care, promotion of parent-infant interaction, family relationships, and community interaction
Other:

Assessment: □ **Well Child** □ **Other diagnosis**
□ **Risk indicators reviewed/screen complete**

Plan/Referrals:
For treatment plans requiring authorization, please complete page 2 on the reverse.

Immunizations: □ **UTD** □ Given, see vaccine record
Labs:

Referrals: □ Developmental
□ RFTS □ BTT □ CSHCN **1-800-642-9704**
□ Other referral(s)

Follow Up/Next Visit:

____
Please print Name of Facility or Clinician

____
Signature of Clinician/Title

Health & Human Resources
BUREAU FOR PUBLIC HEALTH

West Virginia Department of Health and Human Resources
Early and Periodic Screening, Diagnosis,and Treatment (EPSDT)
HealthCheck Program Preventive Health Screen

2 Month Form

Name________________________________DOB_______________Age_________Sex: M F Wt_______Ht_______HC_______Temp_______Pulse__________Screen Date________________

Allergies: □ NKDA ____ Current Meds: □ None ____

Accompanied by: □ Parent □ Grandparent □ Foster parent/organization □ Other ____

History: □ No change
Newborn metabolic screen □ **NL**
Concerns and questions:

Follow up on previous concerns:

Social/Family History: *✓ Check those that apply*
□ No change
□ Family situation change

Caretaker(s) working outside home? □ Yes □ No
Child care? □ No □ Yes ____________________________
Other changes since last visit:

Current Health Indicators: *✓ Check those that apply*
□ No change
Changes since last visit:

□ **GROWTH PLOTTED ON GROWTH CHART**
□ Normal elimination □ Normal sleep patterns
Comments:

Nutrition: □ Breast feeding; Frequency_________________
□ Bottle feeding; Amount_________ Frequency ___________
□ Formula____
□ Vitamins ____
Comments:

□ Passive Smoking Risk: □ Yes □ No

□ **Developmental Surveillance:** *✓Check those that apply*
Gross Motor:
□ Lifts head when prone
□ Holds head erect for periods when held upright
□ Grasps objects

Sensory:
□ Responds to sounds, attentive to voices
□ Follows objects with eyes, shows interest
Communication:
□ Coos
□ Different cries for different needs
Social:
□ Social smile, smiles responsively
□ Shows pleasure in interactions with adults
Comments:

Appropriate Behavior □ Yes □ No

Do you think your child sees OK? □ Yes □ No

Do you think your child hears OK? □ Yes □ No

Oral Health Screen

Water source:
□ Public
□ Well □ Tested

□ Current oral health problems:

Physical Examination: *✓= Normal limits*

□ General Appearance		□ Skin
□ Neurological		□ Reflexes
□ Head	□ Fontanelles	□ Neck
□ Eyes	□ Red Reflex	□ Ocular Alignment
□ Ears	□ Nose	
□ Oral Cavity/Throat		
□ Lungs	□ Heart	□ Pulses
□ Abdomen		□ Genitalia
□ Back	□ Hips	□ Extremities

Abnormal Findings and Comments:
Possible Signs of Abuse □ Yes □ No

Health Education/Anticipatory Guidance:
□ Discussed □ Handout(s) given
Healthy and safe habits: nutrition, sleep, oral/dental care, injury and illness prevention, infant care, promotion of parent-infant interaction, family relationships, and community interaction
Other:

Assessment: □ **Well Child** □ **Other diagnosis**
□ **Risk indicators reviewed/screen complete**

Plan/Referrals:
For treatment plans requiring authorization, please complete page 2 on the reverse.

Immunizations: □ **UTD** □ Given, see vaccine record
Labs:

Referrals: □ Developmental
□ RFTS □ BTT □ CSHCN **1-800-642-9704**
□ Other referral(s)

Follow Up/Next Visit: □ 4 months of age □ Other

____
Please print Name of Facility or Clinician

____
Signature of Clinician/Title

Health & Human Resources
BUREAU FOR PUBLIC HEALTH

West Virginia Department of Health and Human Resources
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
HealthCheck Program Preventive Health Screen

4 Month Form

Name________________________________DOB______________Age_________Sex: M F Wt_______Ht_______HC_______Temp_______Pulse__________Screen Date_______________

Allergies: □ NKDA ____ Current Meds: □ None ____

Accompanied by: □ Parent □ Grandparent □ Foster parent/organization □ Other ____

History: □ No change
Newborn metabolic screen □ **NL**
Concerns and questions:

Follow up on previous concerns:

Recent injuries, illnesses, or visits to other providers:

Social/Family History: *✓ Check those that apply*
□ No change
□ Family situation change

Caretaker(s) working outside home? □ Yes □ No
Child care? □ No □ Yes ______________________________
Other changes since last visit:

Current Health Indicators: *✓ Check those that apply*
□ No change
Changes since last visit:

□ **GROWTH PLOTTED ON GROWTH CHART**
□ Normal elimination □ Normal sleep patterns
Comments:

Nutrition: □ Breast feeding; Frequency________________
□ Bottle feeding; Amount________ Frequency __________
□ Formula_____________________________________
□ Juice □ Water
□ Has started solid foods □ Start solid foods
□ Vitamins _____________________________________
Comments:

□ Passive Smoking Risk: □ Yes □ No

✓ Check those that apply
Hemoglobin/Hematocrit Risk: □ Low risk □ High risk
See Periodicity Schedule for risk indicators

□ **Developmental Surveillance:** *✓ Check those that apply*
Gross Motor:
□ Holds head erect
□ Raises body on hands with head up
□ Rolls front to back

Fine Motor:
□ Reaches for and grabs objects
□ Brings hands together
□ Begins to bat at objects
Sensory:
□ Responds to sounds
□ Follows objects with eyes
□ Looks at and may become excited by mobile
□ Recognizes parent's voice and touch
Communication:
□ Coos
□ Blows bubbles, makes "raspberry sounds"
Social:
□ Social smile
□ Laughs or squeals
□ Able to comfort self (e.g., falls asleep without breast or bottle)
Comments:

Appropriate Behavior □ Yes □ No

Do you think your child sees OK? □ Yes □ No

Do you think your child hears OK? □ Yes □ No

Oral Health Screen

Water source:
□ Public
□ Well □ Tested

□ Current oral health problems:

Physical Examination: *✓= Normal limits*

□ General Appearance		□ Skin
□ Neurological		□ Reflexes
□ Head	□ Fontanelles	□ Neck
□ Eyes	□ Red Reflex	□ Ocular Alignment
□ Ears	□ Nose	
□ Oral Cavity/Throat		
□ Lungs	□ Heart	□ Pulses
□ Abdomen		□ Genitalia
□ Back	□ Hips	□ Extremities

Abnormal Findings and Comments:
Possible Signs of Abuse □ Yes □ No

Health Education/Anticipatory Guidance:
□ Discussed □ Handout(s) given
Healthy and safe habits: nutrition, sleep, oral/dental care, injury and illness prevention, promotion of parent-infant interaction, family relationships, and community interaction
Other:

Assessment: □ **Well Child** □ **Other diagnosis**
□ **Risk indicators reviewed/screen complete**

Plan/Referrals:
For treatment plans requiring authorization, please complete page 2 on the reverse.

Immunizations: □ **UTD** □ Given, see vaccine record
Labs:

Referrals: □ Developmental
□ RFTS □ BTT □ CSHCN **1-800-642-9704**
□ Other referral(s)

Follow Up/Next Visit: □ 6 months of age □ Other

____
Please print Name of Facility or Clinician

____
Signature of Clinician/Title

WVDHHR/BPH/OMCFH/HC 10-2014

West Virginia Department of Health and Human Resources
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
HealthCheck Program Preventive Health Screen

6 Month Form

Name_______________ DOB_______ Age_____ Sex: M F Wt_____ Ht_____ HC_____ Temp_____ Pulse______ Screen Date________

Allergies: □ NKDA ______________ Current Meds: □ None ______________

Accompanied by: □ Parent □ Grandparent □ Foster parent/organization □ Other ______________

History: □ No change
Newborn metabolic screen □ **NL**
Concerns and questions:

Follow up on previous concerns:

Recent injuries, illnesses, or visits to other providers:

Social/Family History: ✓ *Check those that apply*
□ No change
□ Family situation change

Caretaker(s) working outside home? □ Yes □ No
Child care? □ No □ Yes ______________
Other changes since last visit:

Current Health Indicators: ✓ *Check those that apply*
□ No change
Changes since last visit:

□ **GROWTH PLOTTED ON GROWTH CHART**
□ Normal elimination □ Normal sleep patterns
Comments:

Nutrition: □ Breast feeding; Frequency__________
□ Bottle feeding; Amount_____ Frequency ______
□ Formula______________
□ Juice □ Water
□ Has started solid foods □ Normal eating habits
□ Vitamins______________
Comments:

□ Passive Smoking Risk: □ Yes □ No

✓ *Check those that apply*
Tuberculosis Risk: □ Low risk □ High risk
□ Increased risk of exposure d/t Contacts/Travel/Immigration
□ Radiographic or clinical findings suggestive of TB

Lead Risk: □ Low risk □ High risk
□ Lives in or regularly visits a house/child care facility built before 1970 or that has been recently remodeled?
□ Lives near a heavily traveled highway or battery recycling plant or lives with an adult whose job or hobby involves exposure to lead?
□ Has a sibling or playmate who has or did have lead poisoning?

□ **Developmental Surveillance:** ✓ *Check those that apply*
Gross Motor:
□ Sits with support □ Rolls over
□ Stands when placed and bears weight
Fine Motor:
□ Transfers objects from hand to hand
□ Starts to self-feed; grasps and mouths objects
□ Rakes in small objects
Communication:
□ Vocalizes single consonants ("dada", "baba")
□ Babbles, laughs and squeals
□ Plays by making sounds
□ Shows interest in toys
Social:
□ Social smile □ Shows pleasure
□ Shows differential recognition of parents
□ May begin to show signs of stranger anxiety
□ Self comforts
Comments:

Appropriate Behavior □ Yes □ No

Do you think your child sees OK? □ Yes □ No

Do you think your child hears OK? □ Yes □ No

Oral Health Screen

Water source:
□ Public
□ Well □ Tested

□ Current oral health problems:

Physical Examination: ✓*= Normal limits*
□ General Appearance □ Skin
□ Neurological □ Reflexes
□ Head □ Fontanelles □ Neck
□ Eyes □ Red Reflex □ Ocular Alignment
□ Ears □ Nose
□ Oral Cavity/Throat
□ Lungs □ Heart □ Pulses
□ Abdomen □ Genitalia
□ Back □ Hips □ Extremities

Abnormal Findings and Comments:
Possible Signs of Abuse □ Yes □ No

Health Education/Anticipatory Guidance:
□ Discussed □ Handout(s) given
Healthy and safe habits: nutrition, sleep, oral/dental care, injury and illness prevention, infant care, promotion of parent-infant interaction, family relationships, and community interaction
Other:

Assessment: □ **Well Child** □ **Other diagnosis**
□ **Risk indicators reviewed/screen complete**

Plan/Referrals:
For treatment plans requiring authorization, please complete page 2 on the reverse.

Immunizations: □ **UTD** □ Given, see vaccine record
Labs: □ Blood lead, if high risk

Referrals: □ Developmental
□ RFTS □ BTT □ CSHCN **1-800-642-9704**
□ Other referral(s)

Follow Up/Next Visit: □ 9 months of age □ Other

____
Please print Name of Facility or Clinician

____
Signature of Clinician/Title

West Virginia Department of Health and Human Resources
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
HealthCheck Program Preventive Health Screen

9 Month Form

Name________________________________DOB______________Age_________Sex: M F Wt_______Ht_______HC_______Temp_______Pulse_________Screen Date_______________

Allergies: □ NKDA ____ Current Meds: □ None ____

Accompanied by: □ Parent □ Grandparent □ Foster parent/organization □ Other ____

History: □ No change
Concerns and questions:

Follow up on previous concerns:

Recent injuries, illnesses, or visits to other providers:

Social/Family History: *✓ Check those that apply*
□ No change
□ Family situation change

Caretaker(s) working outside home? □ Yes □ No
Child care? □ No □ Yes ____________________________
Other changes since last visit:

Current Health Indicators: *✓ Check those that apply*
□ No change
Changes since last visit:

□ **GROWTH PLOTTED ON GROWTH CHART**
□ Normal elimination □ Normal sleep patterns
Comments:

Nutrition: □ Breast feeding; Frequency_________________
□ Bottle feeding; Amount________ Frequency ___________
□ Formula____
□ Milk □ Juice □ Water
□ Has started solid foods □ Normal eating habits
□ Vitamins_______________________________________
Comments:

□ Passive Smoking Risk: □ Yes □ No

✓ Check those that apply
Lead Risk: □ Low risk □ High risk
□ Lives in or regularly visits a house/child care facility built before 1970 or that has been recently remodeled?
□ Lives near a heavily traveled highway or battery recycling plant or lives with an adult whose job or hobby involves exposure to lead?
□ Has a sibling or playmate who has or did have lead poisoning?

□ **Developmental Surveillance & Screening:**
Standardized Screening Tool:
□ **ASQ3** **Other:**__________________________________
Results in chart/record □ **Yes** □ **No**
Comments:

Appropriate Behavior □ Yes □ No

Do you think your child sees OK? □ Yes □ No

Do you think your child hears OK? □ Yes □ No

Oral Health Screen
Water source:
□ Public
□ Well □ Tested
□ Current oral health problems:

Physical Examination: *✓= Normal limits*

□ General Appearance		□ Skin
□ Neurological		□ Reflexes
□ Head	□ Fontanelles	□ Neck
□ Eyes	□ Red Reflex	□ Ocular Alignment
□ Ears	□ Nose	
□ Oral Cavity/Throat		
□ Lungs	□ Heart	□ Pulses
□ Abdomen		□ Genitalia
□ Back	□ Hips	□ Extremities

Abnormal Findings and Comments:
Possible Signs of Abuse □ Yes □ No

Health Education/Anticipatory Guidance:
□ Discussed □ Handout(s) given
Healthy and safe habits: nutrition, sleep, oral/dental care, injury and illness prevention, infant care, promotion of parent-infant interaction, family relationships, and community interaction
Other:

Assessment: □ **Well Child** □ **Other diagnosis**
□ **Risk indicators reviewed/screen complete**

Plan/Referrals:
For treatment plans requiring authorization, please complete page 2 on the reverse.

Immunizations: □ **UTD** □ Given, see vaccine record
Labs: □ Blood lead, if high risk

Referrals: □ Developmental □ Blood lead $\geq$ 10 ug/dl
□ RFTS □ BTT □ CSHCN **1-800-642-9704**
□ Other referral(s)

Follow Up/Next Visit: □ 12 months of age □ Other

____
Please print Name of Facility or Clinician

____
Signature of Clinician/Title

West Virginia Department of Health & Human Resources BUREAU FOR PUBLIC HEALTH

West Virginia Department of Health and Human Resources
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
HealthCheck Program Preventive Health Screen

12 Month Form

Name________________________DOB___________Age_______Sex: M F Wt______Ht______HC______Temp______Pulse_______Screen Date __________

Allergies: □ NKDA ________________________________ Current Meds: □ None________________________________

Accompanied by: □ Parent □ Grandparent □ Foster parent/organization □ Other ________________________________

History: □ No change
Concerns and questions:

Follow up on previous concerns:

Recent injuries, illnesses, or visits to other providers:

Social/Family History: *✓ Check those that apply*
□ No change
□ Family situation change

Caretaker(s) working outside home? □ Yes □ No
Child care? □ No □ Yes ________________________
Other changes since last visit:

Current Health Indicators: *✓ Check those that apply*
□ No change
Changes since last visit:

□ **GROWTH PLOTTED ON GROWTH CHART**
□ Normal elimination □ Normal sleep patterns
Comments:

Nutrition: □ Breast feeding; Frequency______________
□ Bottle feeding; Amount_______ Frequency ________
□ Formula________________________________
□ Milk □ Juice □ Water
□ Has started solid foods □ Normal eating habits
□ Vitamins________________________________
Comments:

□ Passive Smoking Risk: □ Yes □ No

✓ Check those that apply
Tuberculosis Risk: □ Low risk □ High risk
□ Increased risk of exposure d/t Contacts/Travel/Immigration
□ Radiographic or clinical findings suggestive of TB

□ **Lead Risk: Blood lead required at 12 months**

□ **Developmental Surveillance:** *✓ Check those that apply*
Gross Motor:
□ Pulls self to standing □ Crawls
□ Walks with support
Fine Motor:
□ Feeds self with fingers, drinks from cup
□ Pincer grasp
□ Bangs two blocks together
Communication:
□ Uses 1- 2 words
□ **Imitates vocalizations and sounds***
□ **Babbling***
Social:
□ **Protodeclarative pointing***
□ Social smile □ Waves bye-bye
□ Peekaboo □ Looks at pictures
□ Patty-cake □ Looks for dropped or hidden objects
Comments:

□ ****Absence of these milestones= Autism Screen***

Appropriate Behavior □ Yes □ No

Do you think your child sees OK? □ Yes □ No

Do you think your child hears OK? □ Yes □ No

Oral Health Screen

Water source:
□ Public
□ Well □ Tested
Fluoride □ Yes □ No

□ Tooth eruption
□ Current oral health problems:

Physical Examination: *✓= Normal limits*
□ General Appearance □ Skin
□ Neurological □ Reflexes
□ Head □ Fontanelles □ Neck
□ Eyes □ Red Reflex □ Ocular Alignment
□ Ears □ Nose
□ Oral Cavity/Throat
□ Lungs □ Heart □ Pulses
□ Abdomen □ Genitalia
□ Back □ Hips □ Extremities
□ Gait

Abnormal Findings and Comments:
Possible Signs of Abuse □ Yes □ No

Health Education/Anticipatory Guidance:
□ Discussed □ Handout(s) given
Healthy and safe habits: nutrition, sleep, oral/dental care, injury and violence prevention, social competence, family relationships, and community interaction
Other:

Assessment: □ **Well Child** □ **Other diagnosis**
□ **Risk indicators reviewed/screen complete**

Plan/Referrals:
For treatment plans requiring authorization, please complete page 2 on the reverse.

Immunizations: □ **UTD** □ Given, see vaccine record
Labs: □ **HGB/HCT required at 12 months**
□ **Blood lead required at 12 months**

Referrals: □ **Dentist** □ Developmental
□ Blood lead ≥ 10 ug/dl
□ BTT □ CSHCN **1-800-642-9704**
□ Other referral(s)

Follow Up/Next Visit: □ 15 months of age □ Other

____
Please print Name of Facility or Clinician

____
Signature of Clinician/Title

West Virginia Department of Health & Human Resources Bureau for Public Health

West Virginia Department of Health and Human Resources
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
HealthCheck Program Preventive Health Screen

15 Month Form

Name________________ DOB__________ Age______ Sex: M F Wt_____ Ht_____ HC_____ Temp_____ Pulse______ Screen Date __________

Allergies: □ NKDA ________________ Current Meds: □ None________________

Accompanied by: □ Parent □ Grandparent □ Foster parent/organization □ Other ________________

History: □ No change
Concerns and questions:

Follow up on previous concerns:

Recent injuries, illnesses, or visits to other providers:

Social/Family History: ✓ *Check those that apply*
□ No change
□ Family situation change

Caretaker(s) working outside home? □ Yes □ No
Child care? □ No □ Yes ________________
Other changes since last visit:

Current Health Indicators: ✓ *Check those that apply*
□ No change
Changes since last visit:

□ GROWTH PLOTTED ON GROWTH CHART
□ Normal elimination □ Normal sleep patterns
Comments:

Nutrition: □ Breast feeding; Frequency__________
□ Bottle feeding; Amount_______ Frequency ________
□ Formula________________
□ Milk □ Juice □ Water □ Normal eating habits
□ Vitamins________________
Comments:

□ Passive Smoking Risk: □ Yes □ No

✓ *Check those that apply*
Hemoglobin/Hematocrit Risk: □ Low risk □ High risk
See Periodicity Schedule for risk indicators

Tuberculosis Risk: □ Low risk □ High risk
□ Increased risk of exposure d/t Contacts/Travel/Immigration
□ Radiographic or clinical findings suggestive of TB

Lead Risk: □ Low risk □ High risk
□ Lives in or regularly visits a house/child care facility built before 1970 or that has been recently remodeled?
□ Lives near a heavily traveled highway or battery recycling plant or lives with an adult whose job or hobby involves exposure to lead?
□ Has a sibling or playmate who has or did have lead poisoning?

□ **Developmental Surveillance:** ✓ *Check those that apply*
Gross Motor:
□ Walks well, stoops, climbs stairs
Fine Motor:
□ Feeds self with fingers, drinks from cup
□ Scribbles
□ Stacks 2 blocks
Communication:
□ **Uses 1 word***
□ Uses 3-10 words
□ Indicates what he/she wants by pulling, pointing or grunting
□ Understands simple commands
□ Points to pictures in book
Social:
□ Gives and takes food or toys
□ Throws objects in play
□ Listens to a story
Comments:

□ **Absence of these milestones= Autism Screen*

Appropriate Behavior □ Yes □ No

Do you think your child sees OK? □ Yes □ No

Do you think your child hears OK? □ Yes □ No

Oral Health Screen

Water source:
□ Public
□ Well □ Tested
Fluoride □ Yes □ No

□ Current oral health problems:

Physical Examination: ✓ *= Normal limits*

□ General Appearance		□ Skin
□ Neurological		□ Reflexes
□ Head	□ Fontanelles	□ Neck
□ Eyes	□ Red Reflex	□ Ocular Alignment
□ Ears	□ Nose	
□ Oral Cavity/Throat		
□ Lungs	□ Heart	□ Pulses
□ Abdomen		□ Genitalia
□ Back	□ Hips	□ Extremities

Abnormal Findings and Comments:
Possible Signs of Abuse □ Yes □ No

Health Education/Anticipatory Guidance:
□ Discussed □ Handout(s) given
Healthy and safe habits: nutrition, sleep, oral/dental care, injury and violence prevention, social competence, family relationships, and community interaction
Other:

Assessment: □ **Well Child** □ **Other diagnosis**
□ **Risk indicators reviewed/screen complete**

Plan/Referrals:
For treatment plans requiring authorization, please complete page 2 on the reverse.

Immunizations: □ **UTD** □ Given, see vaccine record
Labs: □ Blood lead, if needed or high risk

Referrals: □ Developmental □ Dentist
□ Blood lead ≥ 10 ug/dl
□ BTT □ CSHCN **1-800-642-9704**
□ Other referral(s)

Follow Up/Next Visit: □ 18 months of age □ Other

____
Please print Name of Facility or Clinician

____
Signature of Clinician/Title

West Virginia Department of Health & Human Resources
Bureau for Public Health

West Virginia Department of Health and Human Resources
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
HealthCheck Program Preventive Health Screen

18 Month Form

Name________________________________DOB______________Age_________Sex: M F Wt_______Ht_______HC_______Temp_______Pulse_________Screen Date_______________

Allergies: □ NKDA ____ Current Meds: □ None ____

Accompanied by: □ Parent □ Grandparent □ Foster parent/organization □ Other ____

History: □ No change
Concerns and questions:

Follow up on previous concerns:

Recent injuries, illnesses, or visits to other providers:

Social/Family History: *✓ Check those that apply*
□ No change
□ Family situation change

Caretaker(s) working outside home? □ Yes □ No
Child care? □ No □ Yes ______________________________
Other changes since last visit:

Current Health Indicators: *✓ Check those that apply*
□ No change
Changes since last visit:

□ **GROWTH PLOTTED ON GROWTH CHART**
□ Normal elimination □ Normal sleep patterns
Comments:

Nutrition: □ Breast feeding; Frequency ________________
□ Bottle feeding; Amount________ Frequency____________
□ Formula ____
□ Milk □ Juice □ Water □ Normal eating habits
□ Vitamins____
Comments:

□ Passive Smoking Risk: □ Yes □ No

✓ Check those that apply
Hemoglobin/Hematocrit Risk: □ Low risk □ High risk
See Periodicity Schedule for risk indicators

Tuberculosis Risk: □ Low risk □ High risk
□ Increased risk of exposure d/t Contacts/Travel/Immigration
□ Radiographic or clinical findings suggestive of TB

Lead Risk: □ Low risk □ High risk
□ Lives in or regularly visits a house/child care facility built before 1970 or that has been recently remodeled?
□ Lives near a heavily traveled highway or battery recycling plant or lives with an adult whose job or hobby involves exposure to lead?
□ Has a sibling or playmate who has or did have lead poisoning?

□ **Developmental Surveillance & Screening:**
Standardized Screening Tool:
□ **ASQ3 Other:**________________________________
Results in chart/record □ **Yes** □ **No**

□ **Autism Screening:**
Autism Specific Screening Tool:
□ **M-CHAT Other:**________________________________
Results in chart/record □ **Yes** □ **No**

Comments:

Gets along with other family members □ Yes □ No

Appropriate Behavior □ Yes □ No

Do you think your child sees OK? □ Yes □ No

Do you think your child hears OK? □ Yes □ No

Oral Health Screen
Date of last dental visit____________________________
Water source:
□ Public
□ Well □ Tested
Fluoride □ Yes □ No
□ Current oral health problems:

Physical Examination: *✓= Normal limits*
□ General Appearance □ Skin
□ Neurological □ Reflexes
□ Head □ Fontanelles □ Neck
□ Eyes □ Red Reflex □ Ocular Alignment
□ Ears □ Nose □ Oral Cavity/Throat
□ Lungs □ Heart □ Pulses
□ Abdomen □ Genitalia
□ Back □ Extremities
□ Hips

Abnormal Findings and Comments:
Possible Signs of Abuse □ Yes □ No

Health Education/Anticipatory Guidance:
□ Discussed □ Handout(s) given
Healthy and safe habits: nutrition, sleep, oral/dental care, injury and violence prevention, social competence, family relationships, and community interaction
Other:

Assessment: □ **Well Child** □ **Other diagnosis**
□ **Risk indicators reviewed/screen complete**

Plan/Referrals:
For treatment plans requiring authorization, please complete page 2 on the reverse.

Immunizations: □ **UTD** □ Given, see vaccine record
Labs: □ Blood lead, if high risk

Referrals: □ Developmental □ Dentist
□ Blood lead ≥ 10 ug/dl
□ BTT □ CSHCN **1-800-642-9704**
□ Other referral(s)

Follow Up/Next Visit: □ 24 months of age □ Other

____
Please print Name of Facility or Clinician

____
Signature of Clinician/Title

West Virginia Department of Health & Human Resources Bureau for Public Health

West Virginia Department of Health and Human Resources
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
HealthCheck Program Preventive Health Screen

24 Month Form

Name________________________________DOB______________Age_________Sex: M F Wt_______Ht_______HC_______Temp_______Pulse__________Screen Date______________

Allergies: □ NKDA ____ Current Meds: □ None ____

Accompanied by: □ Parent □ Grandparent □ Foster parent/organization □ Other ____

History: □ No change
Concerns and questions:

Follow up on previous concerns:

Recent injuries, illnesses, or visits to other providers:

Social/Family History: *✓ Check those that apply*
□ No change
□ Family situation change

Caretaker(s) working outside home? □ Yes □ No
Child care? □ No □ Yes ______________________________
Other changes since last visit:

Current Health Indicators: *✓ Check those that apply*
□ No change
Changes since last visit:

□ **GROWTH PLOTTED ON GROWTH CHART**
□ **BMI CALCULATED AND PLOTTED ON BMI CHART**
□ Normal elimination □ Normal sleep patterns
Comments:

Nutrition: □ Normal eating habits
□ Vitamins: ____
Comments:

□ Passive Smoking Risk: □ Yes □ No

✓ Check those that apply
Hemoglobin/Hematocrit Risk: □ Low risk □ High risk
See Periodicity Schedule for risk indicators

Dyslipidemia Risk: □ Low risk □ High risk
□ Family history of cardiovascular disease
□ Family history of elevated blood cholesterol
□ Cigarette smoking □ Elevated blood pressure
□ Overweight/obesity □ Diabetes
□ Physical inactivity □ Poor dietary habits

Tuberculosis Risk: □ Low risk □ High risk
□ Increased risk of exposure d/t Contacts/Travel/Immigration
□ Radiographic or clinical findings suggestive of TB

□ **Lead Risk: Blood lead required at 24 months**

□ **Developmental Surveillance:** *✓ Check those that apply*
Gross Motor:
□ Runs □ Walk up and down stairs
□ Kicks ball □ Throws ball
Fine Motor:
□ Uses spoon and fork □ Opens a door
□ Makes horizontal and circular strokes with crayon
□ Stacks 5-6 blocks
Communication:
□ Uses 2 word phrases □ ≥20 word vocabulary
□ Follows two-step commands □ Uses pronouns
□ Listens to stories
Cognitive:
□ Hides and finds objects □ Pretend play
□ Problem solve
Social:
□ Parallel play with other children
□ Imitates adults

□ **Autism Screening:**
Autism Specific Screening Tool:
□ **M-CHAT Other:**________________________________
Results in chart/record □ **Yes** □ **No**
Comments:

Ability to separate from parents □ Yes □ No

Gets along with other family members □ Yes □ No

Appropriate Behavior □ Yes □ No

Do you think your child sees OK? □ Yes □ No

Do you think your child hears OK? □ Yes □ No

Oral Health Screen
Date of last dental visit________________________________
Water source:
□ Public
□ Well □ Tested
Fluoride □ Yes □ No
□ Current oral health problems:

Physical Examination: *✓= Normal limits*
□ General Appearance □ Skin
□ Neurological □ Reflexes
□ Head □ Neck
□ Eyes □ Red Reflex □ Ocular Alignment
□ Ears □ Nose □ Oral Cavity/Throat
□ Lungs □ Heart □ Pulses
□ Abdomen □ Genitalia
□ Back □ Extremities

Abnormal Findings and Comments:
Possible Signs of Abuse □ Yes □ No

Health Education/Anticipatory Guidance:
□ Discussed □ Handout(s) given
Healthy and safe habits: nutrition, sleep, oral/dental care, sexuality, injury and violence prevention, social competence, family relationships, and community interaction
Other:

Assessment: □ Well Child □ Other diagnosis
□ Risk indicators reviewed/screen complete

Plan/Referrals:
For treatment plans requiring authorization, please complete page 2 on the reverse.

□ BTT transition planning

Immunizations: □ **UTD** □ Given, see vaccine record
Labs: □ **Blood lead required at 24 months**

Referrals: □ Developmental □ Dentist
□ Blood lead ≥ 10 ug/dl
□ BTT □ CSHCN **1-800-642-9704**
□ Other referral(s)

Follow Up/Next Visit: □ 30 months of age □ Other

____
Please print Name of Facility or Clinician
____
Signature of Clinician/Title

West Virginia Department of Health & Human Resources Bureau for Public Health

West Virginia Department of Health and Human Resources
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
HealthCheck Program Preventive Health Screen

30 Month Form

Name________________________________DOB_______________Age_________Sex: M F Wt_______Ht_______HC_______Temp_______Pulse__________Screen Date_______________

Allergies: ☐ NKDA _______________________________ Current Meds: ☐ None _______________________________

Accompanied by: ☐ Parent ☐ Grandparent ☐ Foster parent/organization ☐ Other _______________________________

History: ☐ No change
Concerns and questions:

Follow up on previous concerns:

Recent injuries, illnesses, or visits to other providers:

Social/Family History: *✓ Check those that apply*
☐ No change
☐ Family situation change

Caretaker(s) working outside home? ☐ Yes ☐ No
Child care? ☐ No ☐ Yes ______________________________
Other changes since last visit:

Current Health Indicators: *✓ Check those that apply*
☐ No change
Changes since last visit:

☐ GROWTH PLOTTED ON GROWTH CHART
☐ BMI CALCULATED AND PLOTTED ON BMI CHART
☐ Normal elimination ☐ Normal sleep patterns
Comments:

Nutrition: ☐ Normal eating habits
☐ Vitamins ______________________________________
Comments:

☐ Passive Smoking Risk: ☐ Yes ☐ No

✓ Check those that apply
Hemoglobin/Hematocrit Risk: ☐ Low risk ☐ High risk
See Periodicity Schedule for risk indicators

Tuberculosis Risk: ☐ Low risk ☐ High risk
☐ Increased risk of exposure d/t Contacts/Travel/Immigration
☐ Radiographic or clinical findings suggestive of TB

Lead Risk: ☐ Low risk ☐ High risk
☐ Lives in or regularly visits a house/child care facility built before 1970 or that has been recently remodeled?
☐ Lives near a heavily traveled highway or battery recycling plant or lives with an adult whose job or hobby involves exposure to lead?
☐ Has a sibling or playmate who has or did have lead

☐ **Developmental Surveillance & Screening:**
Standardized Screening Tool:
☐ **ASQ3** **Other:**______________________________
Results in chart/record ☐ **Yes** ☐ **No**
Comments:

Ability to separate from parents ☐ Yes ☐ No

Gets along with other family members ☐ Yes ☐ No

Appropriate Behavior ☐ Yes ☐ No

Do you think your child sees OK? ☐ Yes ☐ No

Do you think your child hears OK? ☐ Yes ☐ No

Oral Health Screen
Date of last dental visit______________________________
Water source:
☐ Public
☐ Well ☐ Tested
Fluoride ☐ Yes ☐ No
☐ Current oral health problems:

Physical Examination: *✓= Normal limits*

☐ General Appearance		☐ Skin
☐ Neurological		☐ Reflexes
☐ Head		☐ Neck
☐ Eyes	☐ Red Reflex	☐ Ocular Alignment
☐ Ears	☐ Nose	☐ Oral Cavity/Throat
☐ Lungs	☐ Heart	☐ Pulses
☐ Abdomen		☐ Genitalia
☐ Back		☐ Extremities

Abnormal Findings and Comments:
Possible Signs of Abuse ☐ Yes ☐ No

Health Education/Anticipatory Guidance:
☐ Discussed ☐ Handout(s) given
Healthy and safe habits: nutrition, sleep, oral/dental care, sexuality, injury and violence prevention, social competence, family relationships, and community interaction
Other:

Assessment: ☐ **Well Child** ☐ **Other diagnosis**
☐ **Risk indicators reviewed/screen complete**

Plan/Referrals:
For treatment plans requiring authorization, please complete page 2 on the reverse.

☐ BTT transition planning

Immunizations: ☐ **UTD** ☐ Given, see vaccine record
Labs:

Referrals: ☐ Developmental ☐ Dentist
☐ Blood lead ≥ 10 ug/dl
☐ BTT ☐ CSHCN **1-800-642-9704**
☐ Other referral(s)

Follow Up/Next Visit: ☐ 3 years of age ☐ Other

____
Please print Name of Facility or Clinician

____
Signature of Clinician/Title

West Virginia Department of Health & Human Resources Bureau for Public Health

West Virginia Department of Health and Human Resources
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
HealthCheck Program Preventive Health Screen

3 Year Form

Name____________________ DOB__________ Age______ Sex: M F Wt_____ Ht_____ BP_____ Temp_____ Pulse_____ Screen Date__________

Allergies: □ NKDA ____________________ Current Meds: □ None ____________________

Accompanied by: □ Parent □ Grandparent □ Foster parent/organization □ Other ____________________

Health conditions that may require care at school:____________________

□ **Vision Acuity Screen** (obj) R________ L________
□ Unable to obtain, re-screen in 4-6 month

Wears glasses □ Yes □ No

□ **Hearing Screen** (Subjective screen required at 3 years)
Do you think your child hears OK? □ Yes □ No

Wears hearing aids □ Yes □ No

Oral Health Screen
Date of last dental visit____________________
Water source: □ Public □ Well □ Tested
Fluoride □ Yes □ No
□ Current dental problems:

□ **Developmental Surveillance:** *✓ Check those that apply*
Gross Motor:
□ Jumps in place □ Kicks ball □ Rides tricycle
□ Up/down stairs alternating feet
Fine Motor:
□ Uses cup, spoon and fork □ Has manual dexterity
□ Builds a tower with 6 or 8 cubes □ Copies a circle
Communication:
□ Speaks intelligibly □ Uses 3-4 word sentences
□ Short paragraphs □ Uses plurals and pronouns
Cognitive:
□ Follows 2 step instructions □ Aware of gender (of self and others)
□ Knows name, age and sex □ Names most common objects
Social:
□ Listens to stories □ Shows early imaginative behavior
□ Plays interactive games with peers (able to take turns)

Immunizations: Attach current immunization record
□ **UTD** □ Given, see vaccine record
Referrals: □ Developmental □ Dentist □ Vision
□ Hearing □ Blood lead 10≥ug/dl □ CSHCN 1-800-642-9704
□ Other:

Provider signature required for validation
□ Risk indicators reviewed/screen complete

____
Please Print Name of Facility or Clinic

____
Signature of Clinician/Title

The information above this line is intended to be released to meet school entry requirements.

School Entry Requirements

History: □ No change
Concerns and questions:

Follow up on previous concerns:

Recent injuries, illnesses, or visits to other providers:

Social/Family History: *✓ Check those that apply*
□ No change
□ Family situation change

Caretaker(s) working outside home? □ Yes □ No
Child care? □ No □ Yes ____________________
Other changes since last visit:

Current Health Indicators: *✓ Check those that apply*
□ No change
Changes since last visit:

School: Grade______ □ Attends school regularly □ N/A
□ Ability to separate from parents____________________
□ Gets along with other family members

□ **GROWTH PLOTTED ON GROWTH CHART**
□ **BMI CALCULATED AND PLOTTED ON BMI CHART**

□ Normal elimination
□ Normal sleep patterns
□ Appropriate behavior

Nutrition: □ Normal eating habits
□ Vitamins____________________
□ Passive smoking risk □ Yes □ No

✓ Check those that apply
Hemoglobin/Hematocrit Risk: □ Low risk □ High risk
See Periodicity Schedule for risk indicators

Tuberculosis Risk: □ Low risk □ High risk
□ Increased risk of exposure d/t Contacts/Travel/Immigration
□ Radiographic or clinical findings suggestive of TB

Lead Risk: □ Low risk □ High risk
□ Lives in or regularly visits a house/child care facility built before 1970 or that has been recently remodeled?
□ Lives near a heavily traveled highway or battery recycling plant or lives with an adult whose job or hobby involves exposure to lead?
□ Has a sibling or playmate who has or did have lead poisoning?

Physical Examination: *✓ Check those that apply*
□ General Appearance □ Skin
□ Neurological □ Reflexes
□ Head □ Neck
□ Eyes □ Red Reflex □ Ocular Alignment
□ Nose □ Ears □ Oral Cavity/Throat
□ Lungs □ Heart □ Pulses
□ Abdomen □ Genitalia
□ Back □ Extremities

Abnormal Findings and Comments:
Possible signs of abuse □ Yes □ No

Health Education:
□ Discussed □ Handout(s) given
Healthy and safe habits: nutrition, sleep, oral/dental care, sexuality, injury and violence prevention, social competence, school entry, family relationships, and community interaction
Other:

Assessment: □ **Well Child** □ **Other diagnosis**

Plan/Referrals:
For treatment plans requiring authorization, please complete page 2 on the reverse.

Labs: □ Blood lead, if needed or high risk

Referrals: see manual for automatic referrals
□ Other referral(s)

Follow Up/Next Visit: □ 4 years of age □ Other

West Virginia Department of Health and Human Resources
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
HealthCheck Program Preventive Health Screen

4 Year Form

Name___________________DOB__________Age________Sex: M F Wt_______Ht_______BP_______Temp_______Pulse_________Screen Date______________

Allergies: □ NKDA ______________________________ Current Meds: □ None ______________________________

Accompanied by: □ Parent □ Grandparent □ Foster parent/organization □ Other ______________________________

Health conditions that may require care at school:______________________________

□ **Vision Acuity Screen** (obj) R__________ L __________
□ Unable to obtain, re-screen in 4-6 month
Wears glasses □ Yes □ No

□ **Hearing Screen** (obj)
25 db@ 20 db@
R ear:____500HZ R ear:____1000HZ ____2000HZ _____4000HZ
L ear:____500HZ L ear:____1000HZ ____2000HZ _____4000HZ
□ Unable to obtain, re-screen in 4-6 months
Wears hearing aids □ Yes □ No

Oral Health Screen
Date of last dental visit______________________________
Water source: □ Public □ Well □ Tested
Fluoride □ Yes □ No
□ Current dental problems:

□ **Developmental Surveillance:** *✓ Check those that apply*
Gross Motor:
□ Walks, climbs, runs □ Hops, jumps on 1 foot
□ Up/down stairs alternating feet, without support
□ Throws overhand □ Rides bicycle with training wheels
Fine Motor:
□ Builds 10 block tower □ Uses utensils □ Has manual dexterity
□ Draws 3 part person □ Puts on/removes clothes
Communication:
□ Uses past tense □ Talks about daily experiences
□ Speaks intelligibly □ Uses 4-5 word sentences
□ Short paragraphs □ May show some lack of fluency
Cognitive: □ Names 4 colors □ Aware of gender (self and others)
□ Knows difference between fantasy and reality
Social: □ Listens to stories □ Can sing a song
□ Plays interactive games with peers □ Elaborate fantasy play

Immunizations: Attach current immunization record
□ **UTD** □ Given, see vaccine record
Referrals: □ Developmental □ Dentist □ Vision
□ Hearing □ Blood lead 10≥ug/dl □ CSHCN 1-800-642-9704
□ Other:

Provider signature required for validation
□ Risk indicators reviewed/screen complete

____
Please Print Name of Facility or Clinic

____
Signature of Clinician/Title

The information above this line is intended to be released to meet school entry requirements.

School Entry Requirements

History: □ No change
Concerns and questions:

Follow up on previous concerns:

Recent injuries, illnesses, or visits to other providers:

Social/Family History: *✓ Check those that apply*
□ No change
□ Family situation change

Caretaker(s) working outside home? □ Yes □ No
Child care? □ No □ Yes ______________________
Other changes since last visit:

Current Health Indicators: *✓ Check those that apply*
□ No change
Changes since last visit:

School: Grade________□ Attends school regularly □ N/A
□ Ability to separate from parents ______________________
□ Gets along with other family members

□ **GROWTH PLOTTED ON GROWTH CHART**
□ **BMI CALCULATED AND PLOTTED ON BMI CHART**

□ Normal elimination
□ Normal sleep patterns
□ Appropriate behavior

Nutrition: □ Normal eating habits
□ Vitamins______________________
□ Passive smoking risk □ Yes □ No

✓ Check those that apply
Hemoglobin/Hematocrit Risk: □ Low risk □ High risk
See Periodicity Schedule for risk indicators

Dyslipidemia Risk: □ Low risk □ High risk
See Periodicity Schedule for risk indicators

Tuberculosis Risk: □ Low risk □ High risk
See Periodicity Schedule for risk indicators

Lead Risk: □ Low risk □ High risk
Lives in or regularly visits a house/child care facility built before 1970 or that has been recently remodeled?
□ Lives near a heavily traveled highway or battery recycling plant or lives with an adult whose job or hobby involves exposure to lead?
□ Has a sibling or playmate who has or did have lead poisoning?

Physical Examination: *✓ Check those that apply*
□ General Appearance □ Skin
□ Neurological □ Reflexes
□ Head □ Neck
□ Eyes □ Red Reflex □ Ocular Alignment
□ Nose □ Ears □ Oral Cavity/Throat
□ Lungs □ Heart □ Pulses
□ Abdomen □ Genitalia

Abnormal Findings and Comments:
Possible signs of abuse □ Yes □ No

Health Education:
□ Discussed □ Handout(s) given
Healthy and safe habits: nutrition, sleep, oral/dental care, sexuality, injury and violence prevention, social competence, school entry, family relationships, and community interaction
Other:

Assessment: □ **Well Child** □ **Other diagnosis**

Plan/Referrals:
For treatment plans requiring authorization, please complete page 2 on the reverse.

Labs: □ Blood lead, if needed or high risk

Referrals: see manual for automatic referrals
□ Other referral(s)

Follow Up/Next Visit: □ 5 years of age □ Other

West Virginia Department of Health and Human Resources
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
HealthCheck Program Preventive Health Screen

5 Year Form

Name_________________ DOB_________ Age_______ Sex: M F Wt______ Ht______ BP______ Temp______ Pulse_______ Screen Date_________

Allergies: ☐ NKDA ____________ Current Meds: ☐ None ____________

Accompanied by: ☐ Parent ☐ Grandparent ☐ Foster parent/organization ☐ Other ____________

Health conditions that may require care at school: ____________

☐ **Vision Acuity Screen** (obj) R__________ L __________
Wears glasses ☐ Yes ☐ No

☐ **Hearing Screen** (obj)
25 db@ 20 db@
R ear:____500HZ R ear:____1000HZ ____2000HZ _____4000HZ
L ear:____500HZ L ear:____1000HZ ____2000HZ _____4000HZ
Wears hearing aids ☐ Yes ☐ No

Oral Health Screen
Date of last dental visit____________
Water source: ☐ Public ☐ Well ☐ Tested
Fluoride ☐ Yes ☐ No
☐ Current dental problems:

☐ **Developmental Surveillance:** ✓ *Check those that apply*
Gross Motor:
☐ Walks, climbs, runs ☐ May be able to skip
☐ Up/down stairs alternating feet, without support
Fine Motor:
☐ Copies ▲or ■ ☐ Prints some letters
☐ Draws figure w/head, arms and legs ☐ Dresses self
☐ Has manual dexterity
Communication:
☐ Able to recall parts of story ☐ Fluent speech
☐ Uses complete sentences ☐ Speaks in short sentences
☐ Uses future tense ☐ Second language spoken at home
Cognitive:
☐ Knows address and phone # ☐ Can count on fingers
☐ Follows 2-3 step instructions
☐ Recognizes many letters of the alphabet
Social:
☐ Listens to stories ☐ Follows rules
☐ Plays interactive games with peers
☐ Elaborate fantasy play/make believe/dress up

Immunizations: Attach current immunization record
☐ **UTD** ☐ Given, see vaccine record
Referrals: ☐ Developmental ☐ Dentist ☐ Vision
☐ Hearing ☐ Blood lead 10≥ug/dl ☐ CSHCN 1-800-642-9704
☐ Other:

Provider signature required for validation
☐ Risk indicators reviewed/screen complete

____
Please Print Name of Facility or Clinic

____
Signature of Clinician/Title

The information above this line is intended to be released to meet school entry requirements.

School Entry Requirements

History: ☐ No change
Concerns and questions:

Follow up on previous concerns:

Recent injuries, illnesses, or visits to other providers:

Social/Family History: ✓ *Check those that apply*
☐ No change ☐ Family situation change

Caretaker(s) working outside home? ☐ Yes ☐ No
Child care? ☐ No ☐ Yes ____________
Other changes since last visit:

Current Health Indicators: ✓ *Check those that apply*
☐ No change
Changes since last visit:

School: Grade_______ ☐ Attends school regularly ☐ N/A
☐ Ability to separate from parents ____________
Likes most about school____________
Likes least about school____________
☐ Gets along with other family members

☐ **GROWTH PLOTTED ON GROWTH CHART**
☐ **BMI CALCULATED AND PLOTTED ON BMI CHART**
☐ Normal elimination
☐ Normal sleep patterns
☐ Appropriate behavior

Nutrition: ☐ Normal eating habits
☐ Vitamins____________
☐ Passive smoking risk ☐ Yes ☐ No

✓ *Check those that apply*
Hemoglobin/Hematocrit Risk: ☐ Low risk ☐ High risk
See Periodicity Schedule for risk indicators

Tuberculosis Risk: ☐ Low risk ☐ High risk
☐ Increased risk of exposure d/t Contacts/Travel/Immigration
☐ Radiographic or clinical findings suggestive of TB

Lead Risk: ☐ Low risk ☐ High risk
Lives in or regularly visits a house/child care facility built before 1970 or that has been recently remodeled?
☐ Lives near a heavily traveled highway or battery recycling plant or lives with an adult whose job or hobby involves exposure to lead?
☐ Has a sibling or playmate who has or did have lead poisoning?

Physical Examination: ✓ *Check those that apply*
☐ General Appearance ☐ Skin
☐ Neurological ☐ Reflexes
☐ Head ☐ Neck
☐ Eyes ☐ Red Reflex ☐ Ocular Alignment
☐ Nose ☐ Ears ☐ Oral Cavity/Throat
☐ Lungs ☐ Heart ☐ Pulses
☐ Abdomen ☐ Genitalia
☐ Back ☐ Extremities

Abnormal Findings and Comments:
Possible signs of abuse ☐ Yes ☐ No

Health Education:
☐ Discussed ☐ Handout(s) given
Healthy and safe habits: nutrition, sleep, oral/dental care, sexuality, injury and violence prevention, social competence, school entry, family relationships, and community interaction
Other:

Assessment: ☐ Well Child ☐ Other diagnosis

Plan/Referrals:
For treatment plans requiring authorization, please complete page 2 on the reverse.

Labs: ☐ Blood lead, if needed or high risk

Referrals: see manual for automatic referrals
☐ Other referral(s)

Follow Up/Next Visit: ☐ 6 years of age ☐ Other

West Virginia Department of Health and Human Resources
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
HealthCheck Program Preventive Health Screen

6 Year Form

Name________________________________DOB______________Age_________Sex: M F Wt_______Ht_______BP_______Temp_______Pulse_________Screen Date________________

Allergies: □ NKDA ______________________________ Current Meds: □ None ______________________________

Accompanied by: □ Parent □ Grandparent □ Foster parent/organization □ Other ______________________________

Health conditions that may require care at school:______________________________

□ **Vision Acuity Screen** (obj) R___________ L ___________
Wears glasses □ Yes □ No

□ **Hearing Screen** (obj)
25 db@ 20 db@
R ear:____500HZ R ear:____1000HZ ____2000HZ _____4000HZ
L ear:____500HZ L ear:____1000HZ ____2000HZ _____4000HZ
Wears hearing aids □ Yes □ No

Oral Health Screen
Date of last dental visit______________________________
Water source: □ Public □ Well □ Tested
Fluoride □ Yes □ No
□ Current dental problems:

□ **Developmental Surveillance:** ✓ *Check those that apply*
Gross Motor:
□ Backwards tandem walk
□ Balances on each foot with eyes closed-smooth transition
Fine Motor:
□ Ties shoes □ Draws picture of family
Communication:
□ Fluent speech □ Uses complete sentences
Cognitive:
□ Knows name and address □ Knows emergency phone number
□ Prints name □ Prints alphabet
Social:
□ Anger control □ Follows rules

Immunizations: **Attach current immunization record**
□ **UTD** □ Given, see vaccine record

Referrals: □ Developmental □ Dentist □ Vision
□ Hearing □ Blood lead 10≥ug/dl □ CSHCN 1-800-642-9704
□ Other:

Provider signature required for validation
□ Risk indicators reviewed/screen complete

____
Please Print Name of Facility or Clinic

____
Signature of Clinician/Title

The information above this line is intended to be released to meet school entry requirements.

School Entry Requirements

History: □ No change
Concerns and questions:

Follow up on previous concerns:

Recent injuries, illnesses, or visits to other providers:

Social/Family History: ✓ *Check those that apply*
□ No change □ Family situation change
Caretaker(s) working outside home? □ Yes □ No
Child care? □ No □ Yes ______________________________
Other changes since last visit:

Current Health Indicators: ✓ *Check those that apply*
□ No change
Changes since last visit:

Nutrition: □ Normal eating habits
□ Vitamins______________________________
□ Passive smoking risk □ Yes □ No
□ **GROWTH PLOTTED ON GROWTH CHART**
□ **BMI CALCULATED AND PLOTTED ON BMI CHART**
□ Normal elimination □ Normal sleep patterns

✓ *Check those that apply*
Hemoglobin/Hematocrit Risk: □ Low risk □ High risk
See Periodicity Schedule for risk indicators

Dyslipidemia Risk: □ Low risk □ High risk
See Periodicity Schedule for risk indicators

Tuberculosis Risk: □ Low risk □ High risk
See Periodicity Schedule for risk indicators

Lead Risk: □ Low risk □ High risk
Lives in or regularly visits a house/child care facility built before 1970 or that has been recently remodeled?
□ Lives near a heavily traveled highway or battery recycling plant or lives with an adult whose job or hobby involves exposure to lead?
□ Has a sibling or playmate who has or did have lead poisoning?

□ **Behavior:** ✓ *Check those that apply*
Behavior appropriate: □ Yes □ No
Fun activities: □ Yes □ No
Friends: □ Yes □ No
Feelings: □ Content □ Sad □ Angry □ Down/depressed
□ Thoughts/plans to harm □ Self □ Others □ Animals
□ Trouble at school □ Trouble with the law

Risk Indicators: ✓ *Check those that apply* □ None identified
□ Poor self image □ Lack of physical activity
□ Weight or height concerns?______________________________
□ Peer pressure to do things you don't want to do:
____
□ Does not wear protective gear, including seats belts
□ Access to firearms □ Has a firearm
□ Witnessed violence □ Threatened with violence
□ Excessive television/video game use (> 2 hrs. per day)
School: Grade________□ Attends school regularly □ N/A
□ Ability to separate from parents______________________________
Likes most about school______________________________
Likes least about school______________________________
Family: □ Gets along with other family members
If you could, how would you change your family/home?

Physical Examination: ✓ *= Normal limits*
□ General Appearance □ Skin
□ Neurological □ Reflexes
□ Head □ Neck
□ Eye □ Ocular Alignment
□ Nose □ Ears □ Oral Cavity/Throat
□ Lungs □ Heart □ Pulses
□ Abdomen □ Genitalia
□ Back □ Extremities

Abnormal Findings and Comments:
Possible signs of abuse: □ **Yes** □ **No**

Health Education:
□ Discussed □ Handout(s) given
Healthy and safe habits: nutrition, sleep, oral/dental care, sexuality, injury and violence prevention, social competence, school entry, family relationships, and community interaction
Other:

Assessment: □ **Well Child** □ **Other diagnosis**

Plan/Referrals:
For treatment plans requiring authorization, please complete page 2 on the reverse.

Labs: □ Blood lead, if needed or high risk
Referrals: see manual for automatic referrals
□ Other referral(s)

Follow Up/Next Visit: □ 7 years of age □ Other

WVDHHR/BPH/OMCFH/HC 10-2014

West Virginia Department of Health and Human Resources
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
HealthCheck Program Preventive Health Screen

7 & 8 Year Form

Name________________ DOB__________ Age______ Sex: M F Wt______ Ht______ BP______ Temp______ Pulse________ Screen Date__________

Allergies: □ NKDA ______________________ Current Meds: □ None______________________

Accompanied by: □ Parent □ Grandparent □ Foster parent/organization □ Other ______________________

History: □ No change
Concerns and questions:

Follow up on previous concerns:

Recent injuries, illnesses, or visits to other providers:

Social/Family History: *✓ Check those that apply*
□ No change
□ Family situation change

Caretaker(s) working outside home? □ Yes □ No
Child care? □ No □ Yes ______________________
Other changes since last visit:

Current Health Indicators: *✓ Check those that apply*
□ No change
Changes since last visit:

□ **GROWTH PLOTTED ON GROWTH CHART**
□ **BMI CALCULATED AND PLOTTED ON BMI CHART**
□ Normal elimination □ Normal sleep patterns
Comments:

Nutrition: □ Normal eating habits
□ Vitamins:______________________
Comments:

□ Passive Smoking Risk: □ Yes □ No
✓ Check those that apply
Hemoglobin/Hematocrit Risk: □ Low risk □ High risk
See Periodicity Schedule for risk indicators

Dyslipidemia Risk: □ Low risk □ High risk
See Periodicity Schedule for risk indicators

Tuberculosis Risk: □ Low risk □ High risk
See Periodicity Schedule for risk indicators

□ **Behavior/Mental Health Screen:** *✓ Check those that apply*
Appropriate behavior: □ Yes □ No
Fun activities: ______________________
____
Friend(s): □ Yes □ No
Concern(s): □ Yes □ No
Feelings: □ Content
□ Sad □ Less than a week □ More than a week
□ Angry □ Less than a week □ More than a week
□ Down/depressed □ Less than a week □ More than a week
□ Thoughts/plans to harm □ Self □ Others □ Animals
□ Trouble at school □ Trouble with the law

Behavioral concerns/comments: □ Yes □ No

Risk indicators: *✓ Check those that apply* □ None identified
□ Poor self image □ Lack of physical activity
□ Weight or height concerns______________
Exposure to: □ Tobacco, including chew or snuff
□ Alcohol □ Other drugs ______________
□ Peer pressure to do things you don't want to do:
____
□ Inappropriate touching
□ Does not wear protective gear, including seat belts
□ Access to firearms □ Has a firearm
□ Witnessed violence □ Threatened with violence
□ Excessive television/video game use (>2 hrs. per day)
School: Grade______________________
□ Attends school regularly
□ Math at grade level □ Reads at grade level
Likes most about school: ______________________
____
Likes least about school: ______________________
____
Proud of:______________________
____
Participates in activities______________________
□ Special classes______________________

Family/Sexuality:
□ Gets along with other family members
If you could, how would you change your life?
____
home? ______________________
family?______________________
□ Sex education/questions

□ **Vision Acuity Screen** (Sub @ 7yrs, Obj @ 8 yrs)
R_______ L_______

□ **Hearing Screen** (Sub @ 7yrs, Obj@ 8yrs)
R ear: 25 db @____500HZ
20 db@ ____1000HZ ____2000HZ ____4000HZ
L ear: 25 db @____500HZ
20 db@ ____1000HZ ____2000HZ ____4000HZ

Oral Health Screen
Date of last dental visit______________________
Water source:
□ Public □ Well □ Tested
Fluoride □ Yes □ No
□ Current oral health problems:

Physical Examination: *✓= Normal limits*
□ General Appearance □ Skin
□ Neurological □ Reflexes
□ Head □ Neck
□ Eyes □ Ears
□ Nose □ Oral Cavity/Throat
□ Lungs □ Heart □ Pulses
□ Abdomen □ Genitalia
□ Back □ Extremities

Abnormal Findings and Comments:
Possible Signs of Abuse □ Yes □ No

Health Education/Anticipatory Guidance:
□ Discussed □ Handout(s) given
Healthy and safe habits: nutrition, sleep, oral/dental care, risk behaviors, sexuality, injury and violence prevention, social competence, family relationships, and community interaction
Other:

Assessment: □ **Well Child** □ **Other diagnosis**
□ **Risk indicators reviewed/screen complete**

Plan/Referrals:
For treatment plans requiring authorization, please complete page 2 on the reverse.

Immunizations: □ **UTD** □ Given, see vaccine record
Labs:

Referrals*: □ Behavioral/Mental health □ Dentist □ Vision
□ Hearing □ CSHCN **1-800-642-9704**
**See Provider Manual for automatic referrals*
□ Other referral(s)

Follow Up/Next Visit: □ 8 years of age □ 9 years of age
□ Other

____
Please print Name of Facility or Clinician

____
Signature of Clinician/Title

Health & Human Resources
BUREAU FOR PUBLIC HEALTH

West Virginia Department of Health and Human Resources
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
HealthCheck Program Preventive Health Screen

9 & 10 Year Form

Name______________________DOB__________Age______Sex: M F Wt_____Ht_____BP_____Temp_____Pulse______Screen Date__________

Allergies: ☐ NKDA ______________________ Current Meds: ☐ None ______________________

Accompanied by: ☐ Parent ☐ Grandparent ☐ Foster parent/organization ☐ Other ______________________

History: ☐ No change
Concerns and questions:

Follow up on previous concerns:

Recent injuries, illnesses, or visits to other providers:

Social/Family History: *✓ Check those that apply*
☐ No change
☐ Family situation change

Caretaker(s) working outside home? ☐ Yes ☐ No
Child care? ☐ No ☐ Yes ____________________
Other changes since last visit:

Current Health Indicators: *✓ Check those that apply*
☐ No change
Changes since last visit:

☐ **GROWTH PLOTTED ON GROWTH CHART**
☐ **BMI CALCULATED AND PLOTTED ON BMI CHART**
☐ Normal elimination ☐ Normal sleep patterns
Comments:

Nutrition: ☐ Normal eating habits
☐ Vitamins:____________________
Comments:

☐ Passive Smoking Risk: ☐ Yes ☐ No

✓ Check those that apply
Hemoglobin/Hematocrit Risk: ☐ Low risk ☐ High risk
See Periodicity Schedule for risk indicators

Dyslipidemia Risk: ☐ Low risk ☐ High risk
See Periodicity Schedule for risk indicators

Tuberculosis Risk: ☐ Low risk ☐ High risk
See Periodicity Schedule for risk indicators

☐ **Behavior/Mental Health Screen:** *✓ Check those that apply*
Appropriate behavior: ☐ Yes ☐ No
Fun activities: ____________________
____
Friend(s): ☐ Yes ☐ No
Concern(s): ☐ Yes ☐ No
Feelings: ☐ Content
☐ Sad ☐ Less than a week ☐ More than a week
☐ Angry ☐ Less than a week ☐ More than a week
☐ Down/depressed ☐ Less than a week ☐ More than a week
☐ Thoughts/plans to harm ☐ Self ☐ Others ☐ Animals
☐ Trouble at school ☐ Trouble with the law

Behavioral concerns/comments: ☐ Yes ☐ No

Risk indicators: *✓ Check those that apply* ☐ None identified
☐ Poor self image ☐ Lack of physical activity
☐ Weight or height concerns____________
☐ Tobacco use: ☐ Cigarettes/# per day______ ☐ Chew
☐ Alcohol use__________ ☐ Other drug __________
☐ Peer pressure to do things you don't want to do:
____
☐ Inappropriate touching
☐ Does not wear protective gear, including seat belts
☐ Access to firearms ☐ Has a firearm
☐ Witnessed violence ☐ Threatened with violence
☐ Excessive television/video game use (>2 hrs. per day)
School: Grade__________
☐ Attends school regularly
☐ Math at grade level ☐ Reads at grade level
Likes most about school:____________________
____
Likes least about school: ____________________
____
Proud of:____________________
____
Participates in activities____________________
☐ Special classes____________________

Family/Sexuality:
☐ Gets along with other family members
If you could, how would you change your life?
____
home? ____________________
family?____________________
☐ Sex education/questions

☐ **Vision Acuity Screen** (Sub @ 9yrs, Obj @ 10 yrs)
R______ L______

☐ **Hearing Screen** (Sub @ 9yrs, Obj@ 10yrs)
R ear: 25 db @____500HZ
20 db@ ____1000HZ ____2000HZ ____4000HZ
L ear: 25 db @____500HZ
20 db@ ____1000HZ ____2000HZ ____4000HZ

Oral Health Screen
Date of last dental visit____________________
Water source:
☐ Public ☐ Well ☐ Tested
Fluoride ☐ Yes ☐ No
☐ Current oral health problems:

Physical Examination: *✓= Normal limits*
☐ General Appearance ☐ Skin
☐ Neurological ☐ Reflexes
☐ Head ☐ Neck
☐ Eyes ☐ Ears
☐ Nose ☐ Oral Cavity/Throat
☐ Lungs ☐ Heart ☐ Pulses
☐ Abdomen ☐ Genitalia
☐ Back ☐ Extremities

Abnormal Findings and Comments:
Possible Signs of Abuse ☐ Yes ☐ No

Health Education/Anticipatory Guidance:
☐ Discussed ☐ Handout(s) given
Healthy and safe habits: nutrition, sleep, oral/dental care, risk behaviors, sexuality, injury and violence prevention, social competence, family relationships, and community interaction
Other:

Assessment: ☐ **Well Child** ☐ **Other diagnosis**
☐ **Risk indicators reviewed/screen complete**

Plan/Referrals:
For treatment plans requiring authorization, please complete page 2 on the reverse.

Immunizations: ☐ **UTD** ☐ Given, see vaccine record
Labs:

Referrals*: ☐ Behavioral/Mental health ☐ Dentist ☐ Vision
☐ Hearing ☐ CSHCN **1-800-642-9704**
**See Provider Manual for automatic referrals*
☐ Other referral(s)

Follow Up/Next Visit: ☐ 10 years of age ☐ 11 years of age
☐ Other

____
Please print Name of Facility or Clinician

____
Signature of Clinician/Title

WVDHHR/BPH/OMCFH/HC 10-2014

West Virginia Department of Health and Human Resources
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
HealthCheck Program Preventive Health Screen

11, 12, 13 and 14 Year Form

Name________________________________DOB______________Age_________Sex: M F Wt_______Ht_______BP_______Temp_______Pulse_________Screen Date_______________

Allergies: □ NKDA ____ Current Meds: □ None____

Accompanied by: □ Parent □ Grandparent □ Foster parent/organization □ Other ____

History: □ No change
Concerns and questions:

Follow up on previous concerns:

Recent injuries, illnesses, or visits to other providers:

Social/Family History: *✓ Check those that apply*
□ No change
□ Family situation change

Caretaker(s) working outside home? □ Yes □ No
Child care? □ No □ Yes ______________________________
Other changes since last visit:

Current Health Indicators: *✓ Check those that apply*
□ No change □ LMP______________ □ N/A
Changes since last visit:

□ GROWTH PLOTTED ON GROWTH CHART
□ BMI CALCULATED AND PLOTTED ON BMI CHART
□ Normal elimination □ Normal sleep patterns
Comments:

Nutrition: □ Normal eating habits
□ Vitamins:____________________________________
Comments:

□ Passive Smoking Risk: □ Yes □ No
✓ Check those that apply
Hemoglobin/Hematocrit Risk: □ Low risk □ High risk
See Periodicity Schedule for risk indicators

Dyslipidemia Risk: □ Low risk □ High risk
See Periodicity Schedule for risk indicators

Tuberculosis Risk: □ Low risk □ High risk
See Periodicity Schedule for risk indicators

□ ***Depression Screen:** *✓ Check those that apply*
Feelings over the past 2 weeks:
Little interest or pleasure in doing things: □ Not at all
□ Several days □ More than ½ the days □ Nearly every day
Feeling down, depressed, or hopeless: □ Not at all
□ Several days □ More than ½ the days □ Nearly every day
**If Positive see Periodicity Schedule*

□ **Psychosocial/Behavioral Screen:** *✓ Check those that apply*
Appropriate behavior: □ Yes □ No
Fun activities: ____________________________________
____

Friend(s): □ Yes □ No Concern(s): □ Yes □ No
□ Thoughts/plans to harm □ Self □ Others □ Animals
□ Trouble at school □ Trouble with the law
Behavioral concerns/comments: □ Yes □ No

Risk indicators: *✓ Check those that apply* □ None identified
□ Poor self image □ Lack of physical activity
□ Weight or height concerns___________________________
□ Tobacco use: □ Cigarettes/# per day__________ □ Chew
□ *Alcohol use___________ □ *Other drugs_____________
**If positive see Periodicity Schedule*
□ Peer pressure to do things you don't want to do:
____
□ Pressure to have sex □ Inappropriate touching
□ Does not wear protective gear, including seat belts
□ Access to firearms □ Has a firearm
□ Witnessed violence □ Threatened with violence
□ Excessive television/video game use (>2 hrs. per day)
School: Grade______________
□ Attends school regularly
□ Special classes____________________________________
Likes most about school:_____________________________
____
Likes least about school: ____________________________
____
Proud of:____
____
Participates in activities_____________________________
Plans after high school______________________________
Family/Sexuality:
□ Gets along with other family members
If you could, how would you change your life?
____
home? ____
family?____

□ Sex education/questions
Sexually active? □ Yes □ No *STI/HIV______________ □ N/A
**If positive see Periodicity Schedule*
Method of contraception_______________________ □ N/A

□ **Vision Acuity Screen** (Obj @ 12 yrs) R_______ L_______
□ **Hearing Screen** as indicated by risk screen: 20db@
R ear: _____500HZ ____1000HZ ____2000HZ ____4000HZ
L ear: _____500HZ ____1000HZ ____2000HZ ____4000HZ

Oral Health Screen
Date of last dental visit_______________________________
□ Current oral health problems:

Physical Examination: *✓= Normal limits*
□ General Appearance □ Skin
□ Neurological □ Reflexes
□ Head □ Neck
□ Eyes □ Ears
□ Nose □ Oral Cavity/Throat
□ Lungs □ Heart □ Pulses
□ Abdomen □ Genitalia
□ Back □ Extremities

Abnormal Findings and Comments:
Possible Signs of Abuse □ Yes □ No

Health Education/Anticipatory Guidance:
□ Discussed □ Handout(s) given
Healthy and safe habits: nutrition, sleep, oral/dental care, risk behaviors, sexuality, injury and violence prevention, mental health, substance use/abuse, social competence, responsibility, family relationships, community interaction, school achievement, and health care transition from adolescence to adulthood in the medical home (beginning at 14 years)
Other:

Assessment: □ **Well Child** □ **Other diagnosis**
□ **Risk indicators reviewed/screen complete**

Plan/Referrals:
For treatment plans requiring authorization, please complete page 2 on the reverse.

Immunizations: □ **UTD** □ Given, see vaccine record
Labs:

Referrals*: □ Behavioral/Mental health □ Dentist □ Vision
□ Hearing □ CSHCN □ FP **1-800-642-9704**
**See Provider Manual for automatic referrals*
□ Other referral(s)

Follow Up/Next Visit: □ 12 years of age □ 13 years of age
□ 14 years of age □ 15 years of age □ Other

____
Please print Name of Facility or Clinician

____
Signature of Clinician/Title

WVDHHR/BPH/OMCFH/HC 10-2014

Health & Human Resources Bureau for Public Health

West Virginia Department of Health and Human Resources
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
HealthCheck Program Preventive Health Screen

15, 16 and 17 Year Form

Name________________________________DOB______________Age_________Sex: M F Wt_______Ht_______BP_______Temp_______Pulse_________Screen Date_______________

Allergies: □ NKDA ____ Current Meds: □ None____

Accompanied by: □ Parent □ Grandparent □ Foster parent/organization □ Other ____

History: □ No change
Concerns and questions:

Follow up on previous concerns:

Recent injuries, illnesses, or visits to other providers:

Social/Family History: *✓ Check those that apply*
□ No change
□ Family situation change

Caretaker(s) working outside home? □ Yes □ No
Child care? □ No □ Yes ______________________________
Other changes since last visit:

Current Health Indicators: *✓ Check those that apply*
□ No change □ LMP_____________ □ N/A
Changes since last visit:

□ **GROWTH PLOTTED ON GROWTH CHART**
□ **BMI CALCULATED AND PLOTTED ON BMI CHART**
□ Normal elimination □ Normal sleep patterns
Comments:

Nutrition: □ Normal eating habits
□ Vitamins:____________________________________
Comments:

□ Passive Smoking Risk: □ Yes □ No

✓ Check those that apply
Hemoglobin/Hematocrit Risk: □ Low risk □ High risk
See Periodicity Schedule for risk indicators

Dyslipidemia Risk: □ Low risk □ High risk
See Periodicity Schedule for risk indicators

Tuberculosis Risk: □ Low risk □ High risk
See Periodicity Schedule for risk indicators

□ ***Depression Screen:** *✓ Check those that apply*
Feelings over the past 2 weeks:
Little interest or pleasure in doing things: □ Not at all
□ Several days □ More than ½ the days □ Nearly every day
Feeling down, depressed, or hopeless: □ Not at all
□ Several days □ More than ½ the days □ Nearly every day
**If Positive see Periodicity Schedule*

Psychosocial/Behavior Screen: *✓ Check those that apply*
Appropriate behavior: □ Yes □ No
Fun activities: ____________________________
Friend(s): □ Yes □ No Concern(s): □ Yes □ No
□ Thoughts/plans to harm □ Self □ Others □ Animals

□ Trouble at school □ Trouble with the law
Behavioral concerns/comments: □ Yes □ No

Risk indicators: *✓ Check those that apply* □ None identified
□ Poor self image □ Lack of physical activity
□ Weight or height concerns_______________________
□ Tobacco use: □ Cigarettes/# per day__________ □ Chew
□ *Alcohol use___________ □ *Other drugs_____________
**If positive see Periodicity Schedule*
□ Peer pressure to do things you don't want to do:
____
□ Pressure to have sex □ Inappropriate touching
□ Does not wear protective gear, including seat belts
□ Access to firearms □ Has a firearm
□ Witnessed violence □ Threatened with violence
□ Excessive television/video game use (>2 hrs. per day)
School: Grade_______________
□ Attends school regularly
□ Special classes__________________________________
Likes most about school:___________________________
____
Likes least about school: __________________________
____
Proud of:_______________________________________
____
Participates in activities___________________________
Plans after high school_____________________________

Family/Sexuality:
□ Gets along with other family members

If you could, how would you change your life?
____
home? ____
family?____

□ Sex education/questions
Sexually active? □ Yes □ No *STI/HIV_____________□ N/A
**If positive see Periodicity Schedule*
Method of contraception__________________________ □ N/A

□ **Vision Acuity Screen** (Obj @ 15 yrs) R_______ L_______

□ **Hearing Screen** as indicated by risk screen: 20db@
R ear: _____500HZ ____1000HZ ____2000HZ ____4000HZ
L ear: _____500HZ ____1000HZ ____2000HZ ____4000HZ

Oral Health Screen
Date of last dental visit______________________________
□ Current oral health problems:

Physical Examination: *✓= Normal limits*
□ General Appearance □ Skin
□ Neurological □ Reflexes
□ Head □ Neck
□ Eyes □ Ears
□ Nose □ Oral Cavity/Throat
□ Lungs □ Heart □ Pulses
□ Abdomen □ Genitalia
□ Back □ Extremities

Abnormal Findings and Comments:
Possible Signs of Abuse □ Yes □ No

Health Education/Anticipatory Guidance:
□ Discussed □ Handout(s) given
Healthy and safe habits: nutrition, sleep, oral/dental care, risk behaviors, sexuality, injury and violence prevention, mental health, substance use/abuse, social competence, responsibility, school achievement, family relationships, community interaction, and health care transition from adolescence to adulthood in the medical home
Other:

Assessment: □ **Well Child** □ **Other diagnosis**
□ **Risk indicators reviewed/screen complete**

Plan/Referrals:
For treatment plans requiring authorization, please complete page 2 on the reverse.

Immunizations: □ **UTD** □ Given, see vaccine record
Labs:

Referrals*: □ Behavioral/Mental health □ Dentist □ Vision
□ Hearing □ CSHCN □ FP **1-800-642-9704**
**See Provider Manual for automatic referrals*
□ Other referral(s)

Follow Up/Next Visit: □ 16 years of age □ 17 years of age
□ 18 years of age □ Other

____
Please print Name of Facility or Clinician

____
Signature of Clinician/Title

WVDHHR/BPH/OMCFH/HC 10-2014

West Virginia Department of Health and Human Resources
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
HealthCheck Program Preventive Health Screen

18, 19 and 20 Year Form

Name________________ DOB__________ Age______ Sex: M F Wt_____ Ht_____ BP_____ Temp_____ Pulse______ Screen Date________

Allergies: □ NKDA ______________________ Current Meds: □ None______________________

Accompanied by: □ Parent □ Grandparent □ Foster parent/organization □ Other ______________________

History: □ No change
Concerns and questions:

Follow up on previous concerns:

Recent injuries, illnesses, or visits to other providers:

Social/Family History: *✓ Check those that apply*
□ No change
□ Family situation change

Caretaker(s) working outside home? □ Yes □ No
Child care? □ No □ Yes ______________________
Other changes since last visit:

Current Health Indicators: *✓ Check those that apply*
□ No change □ LMP__________ □ N/A
Changes since last visit:

□ GROWTH PLOTTED ON GROWTH CHART
□ BMI CALCULATED AND PLOTTED ON BMI CHART
□ Normal elimination □ Normal sleep patterns
Comments:

Nutrition: □ Normal eating habits
□ Vitamins:______________________
Comments:

□ Passive Smoking Risk: □ Yes □ No

✓ Check those that apply
Hemoglobin/Hematocrit Risk: □ Low risk □ High risk
See Periodicity Schedule for risk indicators

Dyslipidemia Risk: □ Low risk □ High risk
See Periodicity Schedule for risk indicators

Tuberculosis Risk: □ Low risk □ High risk
See Periodicity Schedule for risk indicators

□ ***Depression Screen:** *✓ Check those that apply*
Feelings over the past 2 weeks:
Little interest or pleasure in doing things: □ Not at all
□ Several days □ More than ½ the days □ Nearly every day
Feeling down, depressed, or hopeless: □ Not at all
□ Several days □ More than ½ the days □ Nearly every day
**If Positive see Periodicity Schedule*

□ **Psychosocial/Behavior Screen:** *✓ Check those that apply*
Appropriate behavior: □ Yes □ No
Fun activities: ______________________
Friend(s): □ Yes □ No Concern(s): □ Yes □ No

□ Thoughts/plans to harm □ Self □ Others □ Animals
□ Trouble at school □ Trouble with the law
Behavioral concerns/comments: □ Yes □ No

Risk indicators: *✓ Check those that apply* □ None identified
□ Poor self image □ Lack of physical activity
□ Weight or height concerns______________________
□ Tobacco use: □ Cigarettes/# per day__________ □ Chew
□ *Alcohol use__________ □ *Other drugs__________
**If positive see Periodicity Schedule*
□ Peer pressure to do things you don't want to do:
____
□ Pressure to have sex □ Inappropriate touching
□ Does not wear protective gear, including seat belts
□ Access to firearms □ Has a firearm
□ Witnessed violence □ Threatened with violence
□ Excessive television/video game use (>2 hrs. per day)
School/Vocational Grade__________ □ N/A
□ Attends school regularly
How are you doing in school?______________________
□ Special classes______________________
Likes most about school:______________________
____
Likes least about school: ______________________
____
Proud of:______________________
____
Participates in activities______________________
Career goals ______________________
□ Working □ Satisfied with job
Family/Sexuality:
□ Gets along with other family members
If you could, how would you change your life?
____
home? ______________________
family?______________________
□ Sex education/questions
Sexually active? □ Yes □ No *STI/HIV__________ □ N/A
** If positive see Periodicity Schedule*
Method of contraception______________________ □ N/A

□ **Vision Acuity Screen** (Obj @ 18 yrs) R______ L______
□ **Hearing Screen** as indicated by risk screen: 20db@
R ear: _____500HZ ____1000HZ ____2000HZ ____4000HZ
L ear: _____500HZ ____1000HZ ____2000HZ ____4000HZ

Oral Health Screen
Date of last dental visit______________________
□ Current oral health problems:

Physical Examination: *✓= Normal limits*
□ General Appearance □ Skin
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□ Lungs □ Heart □ Pulses
□ Abdomen □ Genitalia
□ Back □ Extremities

Abnormal Findings and Comments:
Possible Signs of Abuse □ Yes □ No

Health Education/Anticipatory Guidance:
□ Discussed □ Handout(s) given
Healthy and safe habits: nutrition, sleep, oral/dental care, risk behaviors, sexuality, injury and violence prevention, mental health, substance use/abuse, social competence, responsibility, school vocational achievement, family relationships, community interaction, and health care transition from adolescence to adulthood in the medical home
Other:

Assessment: □ **Well Child** □ **Other diagnosis**
□ **Risk indicators reviewed/screen complete**

Plan/Referrals:
For treatment plans requiring authorization, please complete page 2 on the reverse.

Immunizations: □ **UTD** □ Given, see vaccine record
Labs: □ Fasting Lipoprotein Profile (once in late adolescence)

Referrals*: □ Behavioral/Mental health □ Dentist □ Vision
□ Hearing □ CSHCN □ FP **1-800-642-9704**
**See Provider Manual for automatic referrals*
□ Other referral(s)

Follow Up/Next Visit: □ 19 years of age □ 20 years of age
□ Other

____
Please print Name of Facility or Clinician

____
Signature of Clinician/Title