Preventive Care Forms

Age-Specific Encounter Forms (pp. 2 - 19)  Updated 2014

Body Mass Index (BMI) Calculator - Child & Teen (p. 20)  Updated 2014

CDC Growth Charts (pp. 21 -29)  Updated 2014

Medical and Family History Form - English and Spanish (pp. 30 -31)

Objective Hearing and Vision Form (p. 32)  Updated 2015

Updated 2016
### PEDIATRIC VISIT 3 to 5 DAY

**DATE OF SERVICE_________________**

**NAME__________________________________________________**  
**M / F DATE OF BIRTH_______________ AGE_________**

**WEIGHT__________/_______ %  HEIGHT__________/_______ %  HC__________/_______ %  TEMP_______________**

**Signatures:**  
_____________________________________________________________________________________________________________

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Maryland Healthy Kids Program  
2014

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**HISTORY:**  
Family health history documented & updated?_____________  
Perinatal history documented ?_________________  
Concerns: _________________________________________

**PSYCHOSOCIAL ASSESSMENT:**  
**Sleep:**  
Child care:  
Maternal Depression?  
Yes / No  
Support?  
Recent changes in family: (circle all that apply)  
New members, separation, chronic illness, death, recent move,  
loss of job, other___________________________________________

**Environment:**  
Smokers in home? Yes / No

**Violence Assessment:**  
History of injuries, accidents? Yes / No  
Evidence of neglect or abuse? Yes / No  
**Risk Assessment:**  
TB Circle Positive/Negative (Annual)

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**PHYSICAL EXAMINATION**

<table>
<thead>
<tr>
<th>Wnl</th>
<th>Abn</th>
<th>(describe abnormalities)</th>
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<tbody>
<tr>
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<td>Appearance/Interaction</td>
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<td>Neuro/Reflexes/Tone</td>
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<td>Vision (gross assessment)</td>
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<tr>
<td>☐</td>
<td>☐</td>
<td>Hearing (gross assessment)</td>
</tr>
</tbody>
</table>

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**NUTRITIONAL ASSESSMENT:**  
Breast/bottle:  
Amount & frequency ______________________

Bowel/bladder:  
Number of wet______, dry______ in 24 hours?  
Number BM's in 24 hours? __________

Education:  
Hold to feed □  Use of pacifier □  
If breast fed, Vitamin D □  Feed on demand □  Growth spurts □

**ANTICIPATORY GUIDANCE:**  
**Social:**  
Time out for parent □  Parental adjustment □  
Sibling rivalry □

**Parenting:**  
Respond to cry □  Trust-building □  Holding, comfort □

**Play and communication:**  
Crying is communication □  
Voices, mobiles, music, pictures □

**Health:**  
Diaper/skin care □  Bathing & washing hair □  
Sneezing, hiccoughs, soft spot □  
Taking baby's temperature □  Second hand smoke □

**Injury prevention:**  
Rear facing/rear riding infant car seat □  
Sleep on back □  Smoke detector/escape plan □  Hot water set at 120º □  
Choking/suffocation □  Poison control # □  Fall prevention (heights) □  
Hot liquids □  Firearms (owner risk/safe storage) □  Water safety (tub) □  
Don’t leave unattended □

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**PLANS/ORDERS/REFERRALS**

1. Immunizations ordered □

2. Follow-up newborn hearing screen □

3. Next preventive appointment □

4. Referrals for identified problems? (specify)

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Signatures:
PEDiatric VISIT 0 to 1 MONTH

DATE OF SERVICE_________________

NAME__________________________________________________ M / F DATE OF BIRTH_______________ AGE_________

WEIGHT__________/_______% HEIGHT__________/_______% HC__________/_______% TEMP_______________

Signatures:

_____________________________________________________________________________________________________________

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Maryland Healthy Kids Program

2014
PEDiatric visit 2 to 3 months

Date of service __________________

Name ___________________________________________ M / F Date of birth _____________ Age __________

Weight ________/________% Height ________/________% HC _______/_______% Temp __________

Signatures: ___________________________________________________________________________________

https://mmcp.dhmh.maryland.gov/epsdt

Maryland Healthy Kids Program 2014
PEDIATRIC VISIT 4 to 5 MONTHS

NAME_______________________________________________ M / F DATE OF BIRTH____ ___________ AGE__________

WEIGHT__________/________%  HEIGHT__________/________%  HC__________/_______%  TEMP______________

Signatures: ____________________________________________

https://mmcp.dhmh.maryland.gov/epsdt

Maryland Healthy Kids Program 2014
PEDIATRIC VISIT 6 to 8 MONTHS

DATE OF SERVICE________________

NAME___________________________________________ M / F DATE OF BIRTH______________ AGE__________

WEIGHT__________/_______% HEIGHT__________/_______% HC________/______% TEMP______________

Signatures: ___________________________________________________________________________________________

https://mmcp.dhmh.maryland.gov/epsdt

Maryland Healthy Kids Program 2014

HISTORY:
Family health history documented & updated?_____________
Perinatal history documented & updated?_________________
Reactions to immunizations? Yes / No____________________
Concerns: _________________________________________

PSYCHOSOCIAL ASSESSMENT:
Sleep: _____________________________________________________________________________________________
Child care: _________________________________________________________________________________________
Recent changes in family: (circle all that apply)
New members, separation, chronic illness, death, recent move, Loss of job, other

Environment: Smokers in home? Yes / No

Violence Assessment:
History of injuries, accidents? Yes / No
Evidence of neglect or abuse? Yes / No

RISK ASSESSMENT: TB (Annual) LEAD
(Circle) Pos / Neg Pos / Neg

PHYSICAL EXAMINATION
Wnl Abn (describe abnormalities)
□ □ Appearance/Interaction
□ □ Growth
□ □ Skin
□ □ Head/Face/Fontanelles
□ □ Eyes/Red reflex/Cover test
□ □ Ears
□ □ Nose
□ □ Mouth/Gums/Number of Teeth
□ □ Neck/Nodes
□ □ Lungs
□ □ Heart/Pulses
□ □ Chest/Breasts
□ □ Abdomen
□ □ Genitals
□ □ Extremities/Hips/Feet
□ □ Neuro/Reflexes/Tone
□ □ Vision (gross assessment)
□ □ Hearing (gross assessment)

NUTRITIONAL ASSESSMENT:
Breast/bottle: Amount & frequency _______________________
Bowel/bladder: Number of wet_______, dry_______ in 24 hours?
Number BM's in 24 hours? _______
Education: Introduce single ingredient food weekly □
Offer cup □ Jar/table foods □ Avoid small hard foods □
Encourage self-feeding □ Only water in bedtime bottle □

DEVELOPMENTAL SURVEILLANCE: (Observed or Reported)
Social: Shy with strangers □ Resists pull toy □ Plays peek-a-boo □
Fine Motor: Transfers toy hand to hand □ Feeds self crackers □ Works
for toy out of reach □
Language: Dada or Mama (non-specific) □ Turns to voice □
Imitates speech sounds □

Gross Motor: Sits alone □ Stands holding on □
Bears weight on legs □ No head lag when pulled to sitting □

ANTICIPATORY GUIDANCE:
Social: Fear of strangers □ Separation anxiety □
Parenting: Emphasize protection over discipline □
Temper tantrums: ignore, distract □
May need reassurance for separation anxiety □

Play and communication: Water and sand play □
Toys with moving parts, holes, strings to pull □
Beginning speech sounds □

Health: Fluoride if well water □ Second hand smoke □
Clean teeth □ Use sunscreen □

Injury prevention: Rear riding/rear facing infant car seat □
Smoke detector/escape plan □ Baby proof home □
Hot water set at 120° □ Poison control # □
Choking/suffocation □ Fall prevention (heights) □
Firearms (owner risk/safe storage) □ Hot liquids □
Water safety (tub/pool) □ Don’t leave unattended □

PLANS/ORDERS/REFERRALS
1. Immunizations ordered □ ____________________________
2. Lead test, if positive risk assessment □ ____________________________
3. Follow up newborn hearing screen □ ____________________________
4. Fluoride Varnish Applied? Yes / No ____________________________
5. Next preventive appointment at 9 months □ ____________________________
6. Referrals for identified problems? (specify) ____________________________
# PEDIATRIC VISIT 9 to 11 MONTHS

**NAME** ___________________________  
**M / F** ___________________________  
**DATE OF BIRTH** ___________________  
**AGE** _____________________________

**WEIGHT** / ____%  
**HEIGHT** / ____%  
**HC** / ____%  
**TEMP** ___________________________

**HISTORY:**  
Family health history documented & updated?  
Perinatal history documented & updated?  
Reactions to immunizations? Yes / No  
Concerns: ___________________________

**PSYCHOSOCIAL ASSESSMENT:**  
**Sleep:**  
**Recent changes in family:** (circle all that apply)  
New members, separation, chronic illness, death; recent move, loss of job, other___________________________  
**Environment:** Smokers in home? Yes / No  
**Violence Assessment:**  
History of injuries, accidents? Yes / No  
Evidence of neglect or abuse? Yes / No

**RISK ASSESSMENT:**  
**TB (Annual)**  
**LEAD** (Circle)  
Pos / Neg  
Pos / Neg

**PHYSICAL EXAMINATION:**  
Wnl  
Abn  
(describe abnormalities)

☐ ☐ Appearance/Interaction  
☐ ☐ Growth

☐ ☐ Skin

☐ ☐ Head/Face  
☐ ☐ Eyes/Red reflex/Cover test  
☐ ☐ Ears

☐ ☐ Nose

☐ ☐ Mouth/Dentition (# of teeth)

☐ ☐ Neck/Nodes  
☐ ☐ Lungs

☐ ☐ Heart/Pulses  
☐ ☐ Chest/Breasts

☐ ☐ Abdomen  
☐ ☐ Genitals

☐ ☐ Extremities/Hips/Feet  
☐ ☐ Neuro/Reflexes/Tone

☐ ☐ Vision (gross assessment)  
☐ ☐ Hearing (gross assessment)

**NUTRITIONAL ASSESSMENT:**  
**Breast/bottle:** Amount & frequency ___________________________

**Bowel/bladder:** Number of wet____, dry____ in 24 hours?  
Number BM's in 24 hours? _________

**Education:** Jar/table foods [ ] Offer cup [ ] Avoid small hard foods [ ]  
Encourage self-feeding/finger foods [ ] Expect messiness/playing with food [ ] Water only bedtime bottle [ ]

**DEVELOPMENTAL SCREENING:** (With Standardized Tool)  
**REQUIRED**

<table>
<thead>
<tr>
<th>ASQ</th>
<th>☐ PEDs</th>
<th>☐ Other</th>
<th>☐ (specify)</th>
</tr>
</thead>
</table>

**Results:** Wnl [ ] Areas of Concern: ___________________________

**Referral:** Yes / No  
**Where?** ___________________________

**DEVELOPMENTAL SURVEILLANCE:** (Observed or Reported)  
**Social:** Shy with strangers [ ] Plays patty cake [ ]  
Looks for fallen object [ ]  
**Fine Motor:** Bangs two cubes [ ] Pincer grasp [ ] Reaches, grabs [ ] Feeds self [ ] Drinks from cup [ ]  
**Language:** Dada or Mama (specific) [ ] Babbles [ ]  
Imitates speech sounds [ ]

**Gross Motor:** Gets to sitting [ ] Pulls self to stand [ ]

**ANTICIPATORY GUIDANCE:** (Check all that were discussed)  
**Social:** Fear of strangers [ ] Separation anxiety [ ]  
**Parenting:** Emphasize protection over discipline [ ]  
Temper tantrums: ignore, distract [ ] May need reassurance for separation anxiety [ ]

**Play and communication:** Water and sand play [ ] Toys with moving parts, holes, strings to pull [ ] Beginning speech sounds [ ]

**Health:** Fluoride if well water [ ] Second hand smoke [ ]  
Clean teeth with soft toothbrush or cloth [ ] Use sunscreen [ ]

**Injury prevention:** Rear riding/rear facing infant car seat [ ]  
Smoke detector/escape plan [ ] Poison control# [ ]  
Hot liquids [ ] Hot water set at 120º [ ] Water safety (tub, pool) [ ]  
Choking/suffocation [ ] Firearms (owner risk/safe storage) [ ]  
Fall prevention (heights) [ ] Baby proof home [ ]  
Don’t leave unattended [ ]

**PLANS/ORDERS/REFERRALS**

1. Immunizations ordered [ ]

2. Lead test referral (if positive risk assessment) [ ]

3. Fluoride Varnish Applied? Yes / No [ ]

4. Next preventive appointment at 12 months [ ]

5. Referrals for identified problems? (specify) [ ]

______________________________

Signature:

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Maryland Healthy Kids Program 2014
PEDIATRIC VISIT 12 to 14 MONTHS

NAME__________________________________________________________

WEIGHT_________/_________% HEIGHT_________/_________% HC_________/_________% TEMP_________

HISTORY REVIEW/UPDATE: (note changes)
Medical history updated?________________________
Family health history updated?______________________
Reactions to immunizations? Yes / No__________________
Concerns: ____________________________________________

PSYCHOSOCIAL ASSESSMENT:
Sleep: Child care: ___________
Recent changes in family: (circle all that apply)
New members, separation, chronic illness, death, recent move, loss of job, other_________
Environment: Smokers in home? Yes / No_________

Violence Assessment:
History of injuries, accidents? Yes / No_________
Evidence of neglect or abuse? Yes / No________________

RISK ASSESSMENT: TB LEAD
(Circle) Pos / Neg Pos / Neg

PHYSICAL EXAMINATION
Wnl Abn (describe abnormalities)
☐ ☐ Appearance/Interaction Growth
☐ ☐ Skin
☐ ☐ Head/Face
☐ ☐ Eyes/Red reflex/Cover test
☐ ☐ Ears
☐ ☐ Nose
☐ ☐ Mouth/Dental/Number of teeth
☐ ☐ Neck/Nodes
☐ ☐ Lungs
☐ ☐ Heart/Pulses Chest/Breasts
☐ ☐ Abdomen Genitals
☐ ☐ Musculoskeletal Neuro/Reflexes/Tone
☐ ☐ Vision (gross assessment) Hearing (gross assessment)

NUTRITIONAL ASSESSMENT:
Typical diet: (specify foods):

Education: Phase out bottle ☐ Table foods ☐ Vitamins ☐
Decreased appetite ☐ Whole milk until age two ☐
Keep offering new foods ☐ Nutritious snacks ☐

DEVELOPMENTAL SCREENING: (With Standardized Tool)
ASQ: ☐ PEDs ☐ Other: (specify) ________________________
Results: Wnl ☐ Areas of Concern: _______________________
Referred: Yes / No Where: _______________________

DEVELOPMENTAL SURVEILLANCE: (Observed or Reported)
Social: Fear of strangers ☐ Separation anxiety ☐
Fine Motor: Scribbles ☐ Pincer grasp ☐ Drinks from cup ☐

Language: Dada or Mama (specific) ☐ 1 to 3 words ☐
Indicates wants ☐

Gross Motor: Stands alone ☐ “Cruises” ☐ Walks ☐ Stoops and recovers ☐ Plays ball with examiner ☐

ANTICIPATORY GUIDANCE:
Social: Fear of strangers ☐ Separation anxiety ☐
Parenting: Delay toilet training ☐ Negativism ☐ Autonomy ☐
Discipline means to teach ☐ Avoid spanking/slapping ☐

Play and communication: Varied activities ☐
Singing, naming, reading ☐

Health: Fever ☐ Fluoride if well water ☐ Brush teeth ☐
Second hand smoke ☐ Use sunscreen ☐

Injury prevention: Infant car seat ☐ Rear riding seat ☐
Hot liquids ☐ Hot water set at 120° ☐ Water safety (tub, pool) ☐
Choking/suffocation ☐ Poison control # ☐ Baby proof home ☐
Firearms (owner risk/safe storage) ☐ Fall prevention (heights) ☐
Don’t leave unattended ☐ Smoke detector/escape plan ☐

PLANS/ORDERS/REFERRALS
1. Immunizations ordered ☐
2. Lead test/HCT required ☐
3. PPD, if positive risk assessment ☐
4. Has parent renewed MA for infant? ☐
5. Dental visit advised ☐
6. Fluoride Varnish Applied? Yes / No
g___
7. Next preventive appointment at 15 months ☐
8. Referrals for identified problems? (specify)

Signatures:
https://mmcp.dhmh.maryland.gov/epsdt

Maryland Healthy Kids Program 2014
PEDIATRIC VISIT 15 to 17 MONTHS

NAME__________________________________________ M / F DATE OF BIRTH______________ AGE_____________

WEIGHT__________/________% HEIGHT__________/________% HC___________/_______% TEMP______________

HISTORY REVIEW/UPDATE: (note changes)
Medical history updated?
Family health history updated?
Reactions to immunizations? Yes / No
Concerns: _______________________________________

PSYCHOSOCIAL ASSESSMENT:
Sleep: Child care:
Recent changes in family: (circle all that apply)
New members, separation, chronic illness, death, recent move, loss of job, other ____________________________
Environment: Smokers in home? Yes / No
Violence Assessment:
History of injuries, accidents? Yes / No
Evidence of neglect or abuse? Yes / No

RISK ASSESSMENT:   TB  LEAD
(Circle) Pos / Neg Pos / Neg

PHYSICAL EXAMINATION
Wnl  Abn  (describe abnormalities)
☐ ☐ Appearance/Interaction
☐ ☐ Growth
☐ ☐ Skin
☐ ☐ Head/Face
☐ ☐ Eyes/Red reflex/Cover test
☐ ☐ Ears
☐ ☐ Nose
☐ ☐ Mouth/Dental/Number of teeth
☐ ☐ Neck/Nodes
☐ ☐ Lungs
☐ ☐ Heart/Pulses
☐ ☐ Chest/Breasts
☐ ☐ Abdomen
☐ ☐ Genitals
☐ ☐ Musculoskeletal
☐ ☐ Neuro/Reflexes/Tone
☐ ☐ Vision (gross assessment)
☐ ☐ Hearing (gross assessment)

Concerns: _______________________________________

NUTRITIONAL ASSESSMENT:
Typical diet (specify foods):
Education: Only water in bedtime bottle ☐ Keep offering new foods ☐ Strong dislike for certain foods ☐ Phase out bottle, pacifier ☐

DEVELOPMENTAL SCREENING: (With Standardized Tool)
ASQ: ☐ PEDs ☐ Other: ☐ (specify) __________________________
Results: Wnl ☐ Areas of Concern: __________________________
Referred: Yes / No Where? __________________________

DEVELOPMENTAL SURVEILLANCE: (Observed or Reported)
Social: Imitates affection ☐ Helps with simple tasks ☐ Seeks to control others ☐
Parenting: Child may bite, hit ☐ Use time out ☐ Temper tantrums: ignore, distract ☐ Avoid spanking/slapping ☐ Discipline is teaching ☐ Dependence verses autonomy needs ☐
Play and communication: Climbing, dancing, riding toys ☐ Likes to push/pull, empty/fill, open/close ☐ Read stories ☐ Enjoys household articles ☐
Health: Regression during illness/stress ☐ Proper shoes ☐ Teeth brushing ☐ Fluoride if well water ☐ Second hand smoke ☐ Use sunscreen ☐
Injury prevention: Infant car seat ☐ Rear riding seat ☐ Baby proof home ☐ Hot liquids ☐ Hot water set at 120º ☐ Water safety (tub/pool) ☐ Choking/suffocation ☐ Poison control # ☐ Firearms (owner risk/safe storage) ☐ Fall prevention (heights) ☐ Don’t leave unattended ☐ Smoke detector/escape plan ☐

CORD/ORDERS/REFERRALS
1. Immunizations ordered ☐
2. Review lead and HCT results ☐
3. Refer for lead and HCT testing if not available ☐
4. PPD, if positive risk assessment ☐
5. Dental visit advised ☐ or date of last dental exam ____________
6. Fluoride Varnish Applied? Yes / No ______________
7. Next preventive appointment at 18 months ☐
8. Referrals for identified problems? (specify) __________________________

Signatures: _______________________________________

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Maryland Healthy Kids Program 2014
PEDIATRIC VISIT 18 to 23 MONTHS

NAME_______________________________________ DATE OF BIRTH______________ AGE_____________

WEIGHT__________/______% HEIGHT__________/______% HC___________/_____% TEMP__________

HISTORY REVIEW/UPDATE: (note changes)
Medical history updated? _______________________________________________________________
Family health history updated? ___________________________________________________________
Reactions to immunizations? Yes / No __________________________________________________
Concerns:  ____________________________________________________________

PSYCHOSOCIAL ASSESSMENT:
Sleep: ___________________________  Child care: _________________________________
Recent changes in family: (circle all that apply) ___________________________________________
New members, separation, chronic illness, death, recent move, loss of job, other __________________________
Environment: Smokers in home? Yes / No ________________________________________________
Violence Assessment:
History of injuries, accidents? Yes / No ________________________________________________
Evidence of neglect or abuse? Yes / No __________________________________________________

RISK ASSESSMENT:  TB  LEAD
(Circle)  Pos / Neg  Pos / Neg

PHYSICAL EXAMINATION:
Wnl  Abn  (describe abnormalities)
☐  ☐  Appearance/Interaction
☐  ☐  Growth
☐  ☐  Skin
☐  ☐  Head/Face
☐  ☐  Eyes/Red reflex/Cover test
☐  ☐  Ears
☐  ☐  Nose
☐  ☐  Mouth/Dentition (# of teeth)
☐  ☐  Neck/Nodes
☐  ☐  Lungs
☐  ☐  Heart/Pulses
☐  ☐  Chest/Breasts
☐  ☐  Abdomen
☐  ☐  Genitals
☐  ☐  Extremities/Hips/Feet
☐  ☐  Neuro/Reflexes/Tone
☐  ☐  Vision (gross assessment)
☐  ☐  Hearing (gross assessment)

WEIGHT__________/______% HEIGHT__________/______% HC___________/_____% TEMP__________

NUTRITIONAL ASSESSMENT:
Typical diet:
Education:  Prolonged mealtime with playing ☐ Likes and dislikes change often ☐ Food jags okay ☐
Allow self-feeding ☐ Eat with family ☐

DEVELOPMENTAL SCREENING: (With Standardized Tool) REQUIRED
ASQ: ☐ PEDs ☐ Other: ☐ (specify) ________________________________________________
Results: Wnl ☐ Areas of Concern: __________________________________________________
Referred: Yes / No  Where? ________________________________________________________
MCHAT Required ☐
DEVELOPMENTAL SURVEILLANCE; (Observed or Reported)
Social: Removes clothes ☐ Helps with simple tasks ☐ Imitates housework ☐
Fine Motor: Scribbles ☐ Tower of 3-4 cubes ☐ Turns pages ☐
Language: Combines 2 words ☐ Points to 2-4 named body parts ☐
Follows directions ☐ Names picture (cat, bird, horse, dog, person) ☐ Uses 10-15 words ☐

Gross Motor: Kicks ball ☐ Throws ball ☐ Walks up steps ☐
Walks backward ☐

ANTICIPATORY GUIDANCE:
Social: Needs to be independent ☐ Stubbornness is normal ☐ Does not share well ☐

Parenting: Daily routines meet security needs ☐
Child constantly tests parent, self, siblings, environment ☐
"Time out" for hitting/biting ☐ Avoid spanking, slapping ☐
Forgets rules quickly, needs reminding ☐ Give choices ☐

Play and communication: Uses objects for imaginary play ☐
Manipulative toys (play dough, sand, paint) ☐ Read stories ☐
Thumb sucking and masturbation common ☐
Favorite toy, transitional object ☐

Health: May be toilet ready ☐ Brush teeth ☐ Fluoride if well water ☐
Second hand smoke ☐ Use sunscreen ☐

Injury prevention: Infant car seat ☐ Rear riding seat ☐
Hot liquids ☐ Hot water set at 120° ☐ Water safety (tub, pool) ☐
Poison control no. ☐ Choking/suffocation ☐ Baby proof home ☐
Firearms (owner risk/safe storage) ☐ Fall prevention (heights) ☐
Don’t leave unattended ☐ Smoke detector/escape plan ☐

PLANS/ORDERS/REFERRALS:
1. Immunizations ordered ☐
2. Review Lead and HCT results ☐ Refer for testing if none ☐
3. PPD, if risk assessment positive ☐
4. Fluoride Varnish Applied?  Yes  /  No
5. Dental visit advised ☐ or date of last dental visit _____________
6. Next preventive appointment at 2 Years ☐
7. Referrals for identified problems: (specify) ______________________________________

Signatures: ____________________________________________________________

https://mmcp.dhmh.maryland.gov/epsdt  Maryland Healthy Kids Program 2014
**NAME**

**WEIGHT** / % **HEIGHT** / % **BMI** / % **TEMP**

**HISTORY REVIEW/UPDATE:** (note changes)
Medical history updated?
Family health history updated?
Reactions to immunizations? Yes / No
Concerns: ____________________________________________

**PSYCHOSOCIAL ASSESSMENT:**
Sleep: Child care

**Recent changes in family:** (circle all that apply)
New members, separation, chronic illness, death, recent move, loss of job, other ________________________________

Environment: Smokers in home? Yes / No

**Violence Assessment:**
History of injuries, accidents? Yes / No
Evidence of neglect or abuse? Yes / No

**RISK ASSESSMENT:** CHOL TB LEAD
(Circle) Pos / Neg Pos / Neg Pos / Neg

**PHYSICAL EXAMINATION:**
Wnl Abn (describe abnormalities)
- Appearance/Interaction
- Growth
- Skin
- Head/Face
- Eyes/Red reflex/Cover test
- Ears
- Nose
- Mouth/Gums/Dentition
- Neck/Nodes
- Lungs
- Heart/Pulses
- Chest/Breasts
- Abdomen
- Genitals
- Extremities/Hips/Feet
- Neuro/Reflexes/Tone
- Vision (gross assessment)
- Hearing (gross assessment)

**NUTRITIONAL ASSESSMENT:**
Typical diet: (specify foods):
Education: Offer variety of nutritious foods □ 5 fruits/vegetables daily □
Child sized portions □ Avoid struggles over eating □ Eat with family □

**DEVELOPMENTAL SCREENING:** (With Standardized Tool)
**ASQ:** □ PEDs □ Other: (specify) __________________________
Results: Wnl □ Areas of Concern:
Referred: Yes / No Where?

**DEVELOPMENTAL SURVEILLANCE:** (Observed or Reported)
Social: Helps with simple tasks □ Puts on clothing □ Brushes teeth □
Washes and dries hands □ Plays interactive games □
Separates from mother □

**Fine Motor:** Scratches □ Tower of 4-6 cubes □ Copies vertical line □
Uses spoon well □

**Language:** Combines 2 words □ Knows 3-5 named body parts □
Follows 2 part directions □ Understands cold, tired, hungry □
Gives first and last name □ Picks longer line □
Names 1 picture (cat, bird, horse, dog, person) □

**Gross Motor:** Kicks ball □ Runs well □ Walks up steps □ Jumps □
Balances on 1 foot-1 second □ Pedals tricycle □
Throws ball overhand □

**ANTICIPATORY GUIDANCE:** (Check all that were discussed)
Social: Aware of self/different from others □ Needs peer contact □
Dawdling is normal □ Resolving negativism □
Power struggles occur □

**Parenting:** Toilet training (relaxed, praise success) □ Sexuality □
Help teach self-control □ Offer choice, give simple tasks □
Tantrums (ignore, distract, sympathize) □

**Play and communication:** Small table and chairs □
Stories and music □ Building materials □

**Health:** Avoid bubble baths □ Night fears □ Brush teeth □
Fluoride if well water □ Biting, kicking stage □ Use sunscreen □
Physical activity □ Second hand smoke □ Tick prevention □

**Injury prevention:** Car seat □ Rear riding seat □ Poison control □
Hot water at 120° □ Water safety (tub, pool) □ Toddler proof home □
Smoke detector/escape plan □ Hot liquids □ Choking/suffocation □
Firearms (owner risk/safe storage) □ Fall prevention (heights) □

**PLANS**
1. Review immunizations and bring up to date □ __________________________
2. Second Lead/HCT test required □ __________________________
3. Speech referral if delayed □ __________________________
4. PPD, if risk assessment is positive □ __________________________
5. Dental visit advised □ Date of Last Dental Exam __________________________
6. Testing/counseling, if cholesterol risk assessment is positive □ __________________________
7. Fluoride Varnish Applied? Yes / No __________________________
8. Next preventive appointment at 30 Months □ __________________________
9. Referrals for identified problems? (specify) __________________________

**Signatures:**

https://mmcp.dhmh.maryland.gov/epsdt

Maryland Healthy Kids Program 2014
PEDIATRIC VISIT 30 MONTHS

NAME
WEIGHT / %

HEIGHT / %

BMI / %

TEMP

HISTORY REVIEW/UPDATE: (note changes)
Medical history updated? __________________________
Family health history updated? ______________________
Reactions to immunizations? Yes / No______________
Concerns: ________________________________________

PSYCHOSOCIAL ASSESSMENT:
Sleep: Child care:
Recent changes in family: (circle all that apply)
New members, separation, chronic illness, death, recent move, loss of job, other______________________________
Environment: Smokers in home? Yes / No___________
Violence Assessment: History of injuries, accidents? Yes / No
Evidence of neglect or abuse? Yes / No___________

RISK ASSESSMENT: CHOL  TB  LEAD
(Circle) Pos / Neg Pos / Neg Pos / Neg

PHYSICAL EXAMINATION:
Wnl  Abn (describe abnormalities)

☐ ☐ Appearance/Interaction
☐ ☐ Growth
☐ ☐ Skin
☐ ☐ Head/Face
☐ ☐ Ears
☐ ☐ Nose
☐ ☐ Mouth/Gums/Dentition
☐ ☐ Neck/Nodes
☐ ☐ Lungs
☐ ☐ Heart/Pulses
☐ ☐ Chest/Breasts
☐ ☐ Abdomen
☐ ☐ Genitals
☐ ☐ Extremities/Hips/Feet
☐ ☐ Neuro/Reflexes/Tone
☐ ☐ Vision (gross assessment)
☐ ☐ Hearing (gross assessment)

NUTRITIONAL ASSESSMENT:
Typical diet: (specify foods):
Education: Offer variety of nutritious foods □ 5 fruits/vegetables daily □
Child sized portions □ Avoid struggles over eating □ Eat with family □

DEVELOPMENTAL SCREENING: (With Standardized Tool)
REQUIRED if not completed at 24 month visit
ASQ: □ PEDs □ Other: (specify) ____________________
Results: Wnl □ Areas of Concern:
Referral: Yes / No Where?

DEVELOPMENTAL SURVEILLANCE: (Observed or Reported)
Social: Helps with simple tasks □ Puts on clothing □ Brushes teeth □
Washes and dries hands □ Plays interactive games □
Separates from mother □

Fine Motor: Scribbles □ Tower of 4-6 cubes □ Copies vertical line □
Uses spoon well □

Language: Combines 2 words □ Knows 3-5 named body parts □
Follows 2 part directions □ Understands cold, tired, hungry □
Gives first and last name □ Picks longer line □
Names 1 picture (cat, bird, horse, dog, person) □

Gross Motor: Kicks ball □ Runs well □ Walks up steps □ Jumps □
Balances on 1 foot-1 second □ Pedals tricycle □
Throws ball overhand □

ANTICIPATORY GUIDANCE: (Check all that were discussed)
Social: Aware of self/different from others □ Needs peer contact □
Dawdling is normal □ Resolving negativism □
Power struggles occur □

Parenting: Toilet training (relaxed, praise success) □ Sexuality □
Help teach self-control □ Offer choice, give simple tasks □
Tantrums (ignore, distract, sympathize) □

Play and communication: Small table and chairs □
Stories and music □ Building materials □

Health: Avoid bubble baths □ Night fears □ Brush teeth □
Fluoride if well water □ Biting, kicking stage □ Use sunscreen □
Physical activity □ Second hand smoke □ Tick prevention □

Injury prevention: Car seat □ Rear riding seat □ Poison control □
Hot water at 120° □ Water safety (tub, pool) □ Toddler proof home □
Smoke detector/escape plan □ Hot liquids □ Choking/suffocation □
Firearms (owner risk/safe storage) □ Fall prevention (heights) □

PLANS
1. Review immunizations and bring up to date __________________
2. Second Lead/HCT test required □ if not completed at 24 month visit
3. Speech referral if delayed □
4. PPD, if risk assessment is positive □
5. Dental visit advised □ Date of Last Dental Exam __________
6. Testing/counseling, if cholesterol risk assessment is positive __________
7. Fluoride Varnish Applied? Yes / No___________
8. Next preventive appointment at 3 Years __________________________
9. Referrals for identified problems? (specify) ______________________

Signatures:

https://mmcp.dhmh.maryland.gov/epsdt

Maryland Healthy Kids Program 2014
NAME __________________________________________ M / F DATE OF BIRTH ________________ AGE ____________

WEIGHT / %  HEIGHT / %  BMI / %  TEMP  BP ____________________________

HISTORY REVIEW/UPDATE: (note changes)
Medical history updated? ________________________________
Family health history updated? ________________________
Reactions to immunizations? Yes / No __________________
Concerns: __________________________________________

PSYCHOSOCIAL ASSESSMENT:
Sleep: ________________________ Child care: ________________________

Recent changes in family: (circle all that apply)
New members, separation, chronic illness, death, recent move, loss of job, other __________________________

Environment: Smokers in home? Yes / No ______________________

Violence Assessment:
History of injuries, accidents? Yes / No ______________________
Evidence of neglect or abuse? Yes / No ______________________

RISK ASSESSMENT: CHOL  TB  LEAD
(Circle)  Pos / Neg  Pos / Neg  Pos / Neg ______________________

MENTAL HEALTH ASSESSMENT:
Problem identified? Yes / No ______________________________
Counseling provided? Yes / No ______________________________
Referral? Yes / No To: ______________________________

PHYSICAL EXAMINATION
Wnl  Abn  (describe abnormalities)
☐ ☐ Appearance/Interaction  ☐ ☐
☐ ☐ Growth  ☐ ☐
☐ ☐ Skin  ☐ ☐
☐ ☐ Head/Face  ☐ ☐
☐ ☐ Eyes/Red reflex  ☐ ☐
☐ ☐ Cover test/Eye muscles  ☐ ☐
☐ ☐ Ears  ☐ ☐
☐ ☐ Nose  ☐ ☐
☐ ☐ Mouth/ Gums/Dentition  ☐ ☐
☐ ☐ Neck/Nodes  ☐ ☐
☐ ☐ Lungs  ☐ ☐
☐ ☐ Heart/Pulses  ☐ ☐
☐ ☐ Chest/Breasts  ☐ ☐
☐ ☐ Abdomen  ☐ ☐
☐ ☐ Genitals  ☐ ☐
☐ ☐ Musculoskeletal  ☐ ☐
☐ ☐ Neuro/Reflexes  ☐ ☐
☐ ☐ Vision (gross assessment)  ☐ ☐
☐ ☐ Hearing (gross assessment)  ☐ ☐

DATE OF SERVICE ________________________

NUTRITIONAL ASSESSMENT:
Typical diet (specify foods):
Education: Offer variety of nutritious foods/snacks  ☐  May be picky  ☐
Eats same foods as family  ☐  5 fruits/vegetables daily  ☐
No sweetened beverages  ☐

DEVELOPMENTAL SCREENING: (With Standardized Tool)
ASQ: ☐ PEDs  ☐ Other: ☐ (specify) ____________________________
Results: Wnl ☐ Areas of Concern: ____________________________
Referred: Yes / No  Where? ________________________________

DEVELOPMENTAL SURVEILLANCE: (Observed or Reported)
Social: Dresses self  ☐  Separates easily  ☐  Plays interactive games  ☐
Fine Motor: Copies: ☐  + ☐  ☐
Language: Understands 20f 3: cold, tired, hungry ☐
Understands 3 of 4 prepositions (block is on, under, behind in front of table) ☐
Speech clear to examiner  ☐  Recognizes 3-4 colors ☐
Uses plurals  ☐  Gives first and last name  ☐  Knows sex (boy/girl) ☐

Gross Motor: Balances on 1 foot for 1 second  ☐  Jumps well ☐
Broad jump  ☐  Pedals tricycle  ☐

ANTICIPATORY GUIDANCE:
Social: Needs peer contact  ☐  Caution with strangers/animals  ☐
Sibling rivalry  ☐  Develops pride with accomplishments  ☐
Caution with strangers/animals  ☐
Parenting: Time out for serious misbehavior  ☐  Read parenting books  ☐
Help child to release energy  ☐  Avoid smacking, spanking  ☐
Encourage talk about feelings (instead of misbehaving)  ☐
Dependency needs alternate with independence  ☐
Special times alone with child  ☐  Praise child  ☐

Play and communication:  Excursions, outdoor play, art ☐  Library ☐
Read to child ☐  Make up stories together ☐  Screen TV shows ☐

Health: Dental care  ☐  Fears  ☐  Physical activity  ☐
Begin sex education (boy/girl differences, “private parts”, etc) ☐
Masturbation ☐  Fluoride if well water ☐  Tick prevention ☐
Second hand smoke ☐  Use sunscreen ☐

Injury prevention:  Rear riding car seat ☐  Bicycle helmets ☐  Matches ☐
Riding toys in traffic ☐  Smoke detector/escape plan ☐
Poisoning (Plants, drugs, chemicals) ☐  Poison control # ☐
Hot water 120º ☐  Choking/suffocation ☐  Fall prevention (heights) ☐
Firearms (owner risk/safe storage) ☐  Water safety (tub, pool) ☐
Toddler proof home ☐

PLANS/ORDERS/REFERRALS
1. Review immunizations and bring up to date ______________________
2. Review Lead and HCT results ☐  Refer for testing if none ☐
3. PPD, if positive risk assessment ☐
4. Testing/counseling, if positive cholesterol risk assessment ☐
5. Dental visit advised ☐  or date of last visit ______________________
6. Next preventive appointment at 4 Years ☐
7. Referrals for identified problems: (specify) ______________________

Signatures: __________________________________________
https://mmcp.dhmh.maryland.gov/epsdt

Maryland Healthy Kids Program 2014
PEDIATRIC VISIT 4 TO 5 YEARS

NAME _______________________________________

WEIGHT ________ / ______ %  HEIGHT ________ / ______ %

HISTORY REVIEW/UPDATE: (note changes)
Medical history updated? Yes / No ________________________________
Family health history updated? Yes / No ________________________________
Reactions to immunizations? Yes / No ________________________________
Concerns: ________________________________________________________

PSYCHOSOCIAL ASSESSMENT:
Sleep: Child care:__________________________________________________
Recent changes in family: (circle all that apply)
New members, separation, chronic illness, death, recent move, loss of job, other ________________________________

Violence Assessment:
History of injuries, accidents? Yes / No ________________________________
Evidence of neglect or abuse? Yes / No ________________________________

RISK ASSESSMENT: CHOL TB LEAD
(Circle) Pos / Neg Pos / Neg Pos / Neg

MENTAL HEALTH ASSESSMENT:
Problem identified? Yes / No ________________________________
Counseling provided? Yes / No ________________________________
Referral? Yes / No To: ________________________________

PHYSICAL EXAMINATION
Wnl Abn (describe abnormalities)

□ □ Appearance/Interaction
□ □ Growth

□ □ Skin

□ □ Head/Face
□ □ Eyes/Red reflex
□ □ Cover test/Eye muscles

□ □ Ears
□ □ Nose
□ □ Mouth/ Gums/Dentition

□ □ Neck/Nodes
□ □ Lungs

□ □ Heart/Pulses
□ □ Chest/Breasts

□ □ Abdomen
□ □ Genitals

□ □ Musculoskeletal
□ □ Neuro/Reflexes

□ □ Vision (gross assessment)
□ □ Hearing (gross assessment)

Referral? Yes / No To: ________________________________

NUTRITIONAL ASSESSMENT:
Typical diet: (specify foods):

Education: Choose from food guide pyramid □ 2hrs or less TV/day □
Child can help prepare food for meals □ Mealtime can be fun □
5 fruits/vegetables daily □ Food jags □ 1 or more hrs. physical activity □

DEVELOPMENTAL SCREENING: (With Standardized Tool)
ASQ: □ PEDs □ Other: □ (specify) ________________________________
Results: Wnl □ Areas of Concern: ________________________________

DEVELOPMENTAL SURVEILLANCE: (Observed or Reported)

Social: Toilets alone □ Dresses self □ Plays in group □
Separates from parent easily □

Fine Motor: Copies: O □ + □ □ □ □ Uses scissors □ Draws person, 3 parts □

Language: Knows: What is:- spoon □; shoe □; door □; made of?
Fluent sentences □ Recognizes 3-4 colors □ Defines 6-9 words: Ball □
Lake □ Desk □ House □ Banana □ Curtain □ Ceiling □ Fence □
Knows 2-3 opposites: fire is hot, ice is ___ □; mom is woman, dad is ___ □;
horse is big, mouse is ___ □

Gross Motor: Balances on 1 foot for 10 seconds (2-3 times) □
Hops □ Heel-toe walk □ Catches bounced ball □

ANTECIPATORY GUIDANCE:
Social: School readiness □ Enrolled in Pre-K/K □ School avoidance □
Management of aggression □ Promote self-help skills □
Caution with strangers/animals □

Parenting: Allow separation □ Promote initiative, creativity □
Awareness of ADHD and learning disabilities □

Play and communication: Monitor TV use □ Small chores □
Creative, active and group play □
Health: Dental care □ Fluoride if well water □ Bedwetting □ Fears □
Nightmares □ Leg aches □ Normal sexual curiosity; simple answers □
Masturbation □ Oedipal complex □ Use sunscreen □
Tick prevention □ Second hand smoke □

Injury prevention: Booster seat (up to 4’9”) □ Ride in back seat □
Riding toys in traffic environment □ Bicycle helmets □ Matches □
Choking/suffocation □ Hot water 120º □ Water safety (tub, pool) □
Poisoning (Plants, drugs, chemicals) □ Poison control # □
Fall prevention (playground) □ Smoke detector/escape plan □
Firearms (look alike toys, owner risk/safe storage) □

PLANS/ORDERS/REFERRALS
1. Review immunizations and bring up to date □
2. Review Lead and HCT results □ Refer for testing if none □
3. PPD if positive risk assessment □
4. Testing/counseling if positive cholesterol risk assessment □
5. Dental visit advised □ or date of last visit
6. Next preventive appointment at ________________________________
7. Referrals for identified problems: Yes / No (specify)

Signatures: ________________________________ ________________________________

https://mmcp.dhmh.maryland.gov/epsdt

Maryland Healthy Kids Program 2014
PEDIATRIC VISIT 6 to 11 YEARS

NAME____________________________________________

M / F DATE OF BIRTH_________________ AGE__________

WEIGHT_________/____% HEIGHT_________/____% 

BMI_________/____% TEMP______________ BP__________

NUTRITIONAL ASSESSMENT:

Typical diet (specify foods): 

Physical Activities:

At least 1hr. exercise daily? Yes / No

Education: Choose foods from food guide pyramid □ Sociable at table □
Lowfat food choices, including milk □ Choose healthy foods at school □
5 fruits/vegetables daily □ No sweetened beverages □ 2hrs or less TV □

DEVELOPMENTAL SURVEILLANCE:

School: Grade: Performance: 

Peer Relations:

Family Relations:

Extracurricular activities:

Misc. issues:

ANTICIPATORY GUIDANCE:

Social: Responsibility for self □, for school □ Competitiveness □
Family vs. peer activities □ Caution with strangers/animals □
Teach address and phone number □

Parenting: Increased autonomy in decisions □ Communicate □
Praise and encourage □ Give allowance □
Assist in handling money □ Establish fair rules □

Play and communication: Organized sports □ Hobbies □
Monitor TV use □

Health: Dental care □ Fluoride □ Personal hygiene □
Physical activity □ Smoking □ Second hand smoke □
Use sunscreen □ Tick prevention □

Sexuality: Prepare for physical changes □ Early sex education □
Masturbation □ Modesty □

Injury prevention: Seat belt □ Rear seat until age 12 years □

Riding toys in traffic environment □ Bicycle helmets □ Water safety □

Hot water 120º □ Fall prevention (playground) □ Matches □

Protective devices in sports □ Smoke detector/escape plan □

Poisoning (Plants, drugs, products) □ Poison control # □

Firearms (look alike toys; owner risk/safe storage) □

PLANS/ORDERS/REFERRALS

1. Review immunizations and bring up to date □

2. Objective Hearing and Vision Tests (recommended) □

3. PPD, if positive risk assessment □

4. Testing/counseling, if positive cholesterol risk assessment □

5. Dental visit advised □ or date of last visit □

6. Next preventive appointment at □

7. Referrals for identified problems: Yes / No (specify) □

___________________________________________________________________________________

___________________________________________________________________________________

SIGNATURES:

https://mmcp.dhmh.maryland.gov/epsdt

Maryland Healthy Kids Program 2014

Date of Service: ________________________
NAME__________________________________________________________

WEIGHT__________/_____%  HEIGHT__________/_____%  BMI__________/_____%  TEMP__________  BP__________

HISTORY REVIEW/UPDATE: (note changes)
Medical history updated?______________________________________________
Family health history updated?________________________________________
Reactions to immunizations? Yes / No________________________
Concems:____________________________________________________________

PSYCHOSOCIAL ASSESSMENT:
Recent changes in family: (circle all that apply)
New members, separation, chronic illness, death, recent move, loss of job, other________________________
Environment: Smokers in home? Yes / No________________________
Violence Assessment: (interview separately)
Any fears of partner/other violence? Yes / No________________________
Access to gun/weapon? Yes / No_____________________________________

SUBSTANCE ABUSE ASSESS/SCREENING:
Pos / Neg For: ________________________ Cunseled? Yes / No____________
Referral: Yes / No  To: ____________________________________________________

MENTAL HEALTH ASSESSMENT:
Problem identified? Yes / No________________________
Counseling provided? Yes / No________________________________________
Referral? Yes / No  To: __________________________________________________

RISK ASSESSMENT: CHOL  TB  STI/HIV
(Circle) Pos / Neg  Pos / Neg  Pos / Neg

PHYSICAL EXAMINATION
Wnl  Abn (describe abnormalities)
☐ ☐ Appearance/Interaction
☐ ☐ Growth
☐ ☐ Skin
☐ ☐ Head/Face
☐ ☐ Eyes/Red reflex
☐ ☐ Cover test/Eye muscles
☐ ☐ Ears
☐ ☐ Nose
☐ ☐ Mouth/Gums/Dentition
☐ ☐ Neck/Nodes
☐ ☐ Lungs
☐ ☐ Heart/Pulses
☐ ☐ Chest/Breasts
☐ ☐ Abdomen
☐ ☐ Genitals/Tanner Stage/Pelvic/GU
☐ ☐ Age at menarche  LMP
☐ ☐ Musculoskeletal
☐ ☐ Neuro/Reflexes
☐ ☐ Vision (gross assessment)
☐ ☐ Hearing (gross assessment)

Signatures:

https://mmcp.dhmh.maryland.gov/epsdt

Maryland Healthy Kids Program  2014

DATE OF SERVICE_____________________
M / F  DATE OF BIRTH_________________  AGE_________  NUTRITIONAL ASSESSMENT:

Typical diet: (specify foods):

Symptoms of eating disorders? Yes / No

Physical Activities:
At least 1hr. exercise daily? Yes / No

Education: Choose variety of foods ☐  Sociable at table ☐  
Avoid fad diets/eating disorders ☐  Select healthy snacks ☐ 
5 fruits/vegetables daily ☐  2 hrs or less of TV/computer games ☐

DEVELOPMENTAL SURVEILLANCE:
Name of School: Grade: Performance:

Peer Relations:

Family Relations:

Extracurricular activities:

Misc. issues:

ANTICIPATORY GUIDANCE:
Social: Family and peer activities ☐ Ownership and competition ☐ 
Responsibility for self and family ☐  ETOH use ☐ Drug Abuse ☐ 

Parenting: Establish fair, negotiable rules ☐  Money, allowance ☐ 
Promote mutual & self-respect ☐  Respect privacy ☐  Allow decisions ☐ 
Spend time with child talking, projects ☐

Play and communication: Organized sports ☐ 
Monitor TV and internet use ☐

Health: Dental care ☐  Fluoride ☐  Personal hygiene ☐  Smoking ☐
Second hand smoke ☐ Use sunscreen ☐  Tick prevention ☐

Sexuality: Prepare for physical changes ☐  Masturbation ☐ 
Modesty ☐  Sexual Responsibility ☐/STDs ☐

Injury prevention:  Seat belt ☐  Bicycle helmet ☐  Riding in traffic ☐
Smoke detector/escape plan ☐  Poison control # ☐  Water safety ☐
Protective devices in sports ☐  Alcohol/drug use ☐
Firearms (look alike toys; owner risk/safe storage) ☐

PLANS/ORDERS/REFERRALS

1. Review immunizations and bring up to date ☐

2. Recommend objective Hearing and Vision Tests ☐

3. PPD if positive risk assessment ☐

4. Testing/counseling if positive cholesterol risk assessment ☐

5. Testing if positive STD/HIV risk assessment ☐

6. Testing for sickle cell trait if original metabolic results not available ☐

7. Dental visit advised ☐

8. Next preventive appointment at _____________________________

9. Referrals for identified problems: Yes / No (specify)__________________
PEDIATRIC VISIT 12 TO 13 YEARS

NAME__________________________________________

WEIGHT_________/_____% HEIGHT_________/_____%

HISTORY REVIEW/UPDATE: (note changes)
Medical history updated?_____________________
Family health history updated?_________________
Reactions to immunizations? Yes / No________
Concns:_____________________________________

PSYCHOSOCIAL ASSESSMENT:
Recent changes in family: (circle all that apply)
New members, separation, chronic illness, death, recent move, loss of job, other__________________

Environment: Smokers in home? Yes / No________

Violence Assessment: (interview separately)
Any fears of partner/other violence? Yes / No______
Access to gun/weapon? Yes / No________________

SUBSTANCE ABUSE ASSESS/SCREENING:
Pos / Neg For: ___________________________ Counseled? Yes / No______
Referral: Yes / No To:________________________

MENTAL HEALTH ASSESSMENT:
Problem identified? Yes / No_________________
Counseling provided? Yes / No_________________
Referral? Yes / No To:________________________

RISK ASSESSMENT: CHOL TB STI/HIV
(Circle) Pos / Neg Pos / Neg Pos / Neg

PHYSICAL EXAMINATION
Wnl Abn (describe abnormalities)
☐☐ Appearance/Interaction
☐☐ Growth

☐☐ Skin
☐☐ Head/Face
☐☐ Eyes/Red reflex
☐☐ Cover test/Eye muscles
☐☐ Ears
☐☐ Nose
☐☐ Mouth/Gums/Dentition

☐☐ Neck/Nodes
☐☐ Lungs

☐☐ Heart/Pulses
☐☐ Chest/Breasts

☐☐ Abdomen
☐☐ Genitals/Tanner Stage/Pelvic/GU
☐☐ Age at menarche LMP_____
☐☐ Musculoskeletal
☐☐ Neuro/Reflexes

☐☐ Vision (gross assessment)
☐☐ Hearing (gross assessment)

NUTRITIONAL ASSESSMENT:

Typical diet: (specify foods):________
Symptoms of eating disorders? Yes / No

Physical Activities:
At least 1hr. exercise daily? Yes / No

Education: Choose variety of foods □ Sociable at table □
Avoid fad diets/eating disorders □ Select healthy snacks □
5 fruits/vegetables daily □ 2 hrs or less of TV/computer games □

DEVELOPMENTAL SURVEILLANCE:
Name of School: Grade: Performance:

Peer Relations:

Family Relations:

Extracurricular activities:

Misc. issues:

ANTICIPATORY GUIDANCE:
Social: Family and peer activities □ Ownership and competition □
Responsibility for self and family □ ETOH use □ Drug Abuse □

Parenting: Establish fair, negotiable rules □ Money, allowance □
Promote mutual & self-respect □ Respect privacy □ Allow decisions □
Spend time with child talking, projects □

Play and communication: Organized sports □
Monitor TV and internet use □

Health: Dental care □ Fluoride □ Personal hygiene □ Smoking □
Second hand smoke □ Use sunscreen □ Tick prevention □

Sexuality: Prepare for physical changes □ Masturbation □
Modesty □ Sexual Responsibility □ STDs □

Injury prevention: Seat belt □ Bicycle helmet □ Riding in traffic □
Smoke detector/escape plan □ Poison control # □ Water safety □
Protective devices in sports □ Alcohol/drug use □
Firearms (look alike toys; owner risk/safe storage) □

PLANS/ORDES/REFERRALS
1. Review immunizations and bring up to date □_________________
2. Recommend objective Hearing and Vision Tests □________
3. PPD if positive risk assessment □_______________________
4. Testing/counseling if positive cholesterol risk assessment □________
5. Testing if positive STD/HIV risk assessment □_________________
6. Testing for sickle cell trait if original metabolic results not available □
7. Dental visit advised □ or date of last visit_________________
8. Next preventive appointment at _________________________
9. Referrals for identified problems: Yes / No (specify)_________________

Signatures:

https://mmcp.dhmh.maryland.gov/epsdt

Maryland Healthy Kids Program 2014
### PEDIATRIC VISIT 14 TO 16 YEARS

**NAME__________________________**  
**DATE OF SERVICE___________________**  
**M / F**  
**DATE OF BIRTH____________________**  
**BMI__________/_____%**  
**HEIGHT__________/_____%**  
**AGE__________**  
**TEMP___________**  
**BP________________**

#### HISTORY REVIEW/UPDATE: (note changes)
- Medical history updated? Yes / No
- Family health history updated? Yes / No
- Reactions to immunizations? Yes / No
- Concerns: _______________________

#### PSYCHOSOCIAL ASSESSMENT:
- **Recent changes in family**: (circle all that apply)
  - New members, separation, chronic illness, death, recent move, loss of job, other___________________________
- **Environment**: Smokers in home? Yes / No
- **Violence Assessment**: (interview separately)
  - Any fears of partner/other violence? Yes / No
  - Access to gun/weapon? Yes / No

#### SUBSTANCE ABUSE ASSESS/SCREENING:
- Pos / Neg For: ____________________  
  - Counselled? Yes / No
  - Referral: Yes / No  
  - To: ____________________________

#### RISK ASSESSMENT: CHOL  TB  STI/HIV
- (Circle)  
  - Pos / Neg  
  - Pos / Neg  
  - Pos / Neg

#### MENTAL HEALTH ASSESSMENT:
- Problem identified? Yes / No
- Counseling provided? Yes / No
- Referral? Yes / No  
  - To: ____________________________

#### PHYSICAL EXAMINATION
<table>
<thead>
<tr>
<th>Wnl</th>
<th>Abn</th>
<th>(describe abnormalities)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>Appearance/Interaction</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Growth (symptoms of eating disorders?)</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Skin</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Head/Face</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Eyes/Red reflex</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Cover test/Eye muscles</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Ears</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Nose</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Mouth/Gums/Dentition</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Neck/Nodes</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Lungs</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Heart/Pulses</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Chest/Breasts</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Abdomen</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Genitals/Tanner Stage/Pelvic/GU</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Age at menarche ________ LMP__________</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Musculoskeletal</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Neuro/Reflexes</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Vision (gross assessment)</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Hearing (gross assessment)</td>
</tr>
</tbody>
</table>

#### Nutritional Assessment:
- **Typical diet**: (specify foods):
  - Symptoms of eating disorder? Yes / No

#### Physical Activities:
- At least 1hr. exercise daily? Yes / No

#### Education:
- Food sources of iron, calcium, folic acid □
- Select healthy foods □ Prevent obesity □ Eat breakfast □
- Avoid eating disorders/fad diets □ 2 hrs or less of TV/computer games □
- 5 fruits/vegetables daily □ No sweetened beverages □

#### DEVELOPMENTAL SURVEILLANCE:
- **Name of School**: Grade: Performance:  
  - **Peer Relations**:  
  - **Family Relations**:  
  - **Extracurricular activities**:  
  - **Misc. issues**:  

#### ANTICIPATORY GUIDANCE:
- **Social**: Confidentiality □ Peer group pressures □ Mood swings □
  - Dependence vs. independence □ Establishing own values □
  - Social misconduct due to family dysfunctions □ Future plans □
  - Stay in school □ Love life □ ETOH use □ Drug Abuse □
- **Parenting**: Establish fair, negotiable rules □ Allow decisions □
  - Provide support, encouragement □ Money, allowance □
  - Promote mutual respect □ Respect privacy □
- **Health**: Dental care □ Personal hygiene □ Fluoride □ Menstruation □
  - Breast/testicular self-exam □ Smoking □ Second hand smoke □ Use sunscreen □ Tick prevention □
- **Sexuality**: Prepare for physical changes □ Birth control □ STDs □
  - Sexual Responsibility □
- **Injury prevention**: Seat belt □ Alcohol/drug use □ Bicycle helmets □
  - Protective devices in sports □ Water safety □
  - Smoke detector/escape plan □ Firearms (owner risk/safe storage) □

#### PLANS/ORDERS/REFERRALS
1. Review immunizations and bring up to date □
2. PPD, if positive risk assessment □
3. Recommend Objective Hearing and Vision Tests □
4. Testing/counseling if positive cholesterol risk assessment □
5. Testing if positive STD/HIV risk assessment □
6. Dental visit advised □ or date of last visit__________________
7. Next preventive appointment at ____________________________
8. Referrals for identified problems: Yes / No (specify)

---

**Signatures:**

[https://mmcp.dhmh.maryland.gov/epsdt](https://mmcp.dhmh.maryland.gov/epsdt)

Maryland Healthy Kids Program 2014
NAME_________________________________________ M / F DATE OF BIRTH______________ AGE__________
WEIGHT________/ % HEIGHT________/ %
BMI________/ % TEMP________ BP________

DATE OF SERVICE___________________

HISTORY REVIEW/UPDATE: (note changes)
Medical history updated? _________________________
Family health history updated? _________________________
Reactions to immunizations? Yes / No_____________________
Concerns: _______________________________________ (Circle)

NUTRITIONAL ASSESSMENT:
Typical diet (specify foods):
Symptoms of eating disorder? Yes / No

Physical Activities:
At least 1hr. exercise daily? Yes / No

Education: Select healthy foods □ Use skin milk/and lowfat foods □
Avoid fad diets □ 2 hrs or less of TV/computer games □
5 fruits/vegetables daily □ No sweetened beverages □
Vitamin/mineral supplements, folic acid for females □ Eat breakfast □

DEVELOPMENTAL SURVEILLANCE:
Name of School: __________________________ Performance: __________________________

Peer Relations: __________________________
Family Relations: __________________________
Extracurricular activities: __________________________
Misc. issues: __________________________

ANTICIPATORY GUIDANCE:
Social: Love life □ Peer groups pressures □ Mood swings □
Social misconduct resulting from family dysfunctions □
Establishing own values □ Future plans □ Stay in school □

Parenting: Support □ Prepare for independence □

Health: Dental care □ Fluoride □ Personal hygiene □ Smoking □
Second hand smoke □ Menstruation □ Breast/testicular self-exam □
Physical activity □ Use sunscreen □ Tick prevention □

Sexuality: Birth control □ Sexual Responsibility □ STDs □

Injury prevention: Seat belt □ Bicycle helmets □
Protective devices in sports □ Smoke detector/escape plan □
Firearms (owner risk/safe storage) □ Alcohol/drug use □

PLANS/ORDERS/REFERRALS
1. Review immunizations and bring up to date □
2. PPD if positive risk assessment □
3. Testing/counseling if positive cholesterol risk assessment □
4. Testing if positive STD/HIV risk assessment □
5. Dental visit advised □ or date of last visit □
6. Next preventive appointment at □
7. Referrals for identified problems: Yes / No (specify)

________________________________________

SIGNATURES: __________________________

________________________________________

Maryland Healthy Kids Program

https://mmcp.dhmh.maryland.gov/epsdt

2014
BMI Percentile Calculator for Child and Teen
English Version

This calculator provides BMI and the corresponding BMI-for-age percentile on a CDC BMI-for-age growth chart. Use this calculator for children and teens, aged 2 through 19 years old. For adults, 20 years old and older, use the Adult BMI Calculator (http://www.cdc.gov/healthyweight/assessing/bmi/adult_BMI/english_bmi_calculator/bmi_calculator.htm).

Measuring Height and Weight Accurately At Home (http://www.cdc.gov/healthyweight/assessing/bmi/childrens_BMI/measuring_children.html)

BMI Calculator for Child and Teen

(English | Metric (Calculator.aspx?CalculatorType=Metric))

1. Birth Date:
   Month ▼ Day ▼ Year ▼

2. Date of Measurement:
   Month ▼ Day ▼ Year ▼

3. Sex:
   □ Boy □ Girl

4. Height, to nearest 1/8 inch:
   Feet ▼ Inches ▼ Fractions of an inch
   0 ▼ 0 ▼ 0 ▼
   (12 inches = 1 foot; Example: 4 feet, 5 1/2 inches)

5. Weight, to nearest 1/4 (.25) pound:
   Weight (pounds): Fractions of a pound:
   0 ▼ 0 ▼
(8 ounces = 1/2 pounds; Example: 75 3/4 pounds)

Note: Please keep in mind that this BMI calculator is not meant to serve as a source of clinical guidance and is not intended to be a substitute for professional medical advice. Because BMI is based on weight and height, it is only an indicator of body fatness. Individuals with the same BMI may have different amounts of body fat. Persons may consider seeking advice from their health-care providers on healthy weight status and to consider individual circumstances.
Birth to 24 months: Boys
Head circumference-for-age and Weight-for-length percentiles

Published by the Centers for Disease Control and Prevention, November 1, 2009
Birth to 24 months: Girls
Head circumference-for-age and
Weight-for-length percentiles

Published by the Centers for Disease Control and Prevention, November 1, 2009
Birth to 24 months: Girls
Length-for-age and Weight-for-age percentiles

Published by the Centers for Disease Control and Prevention, November 1, 2009
### 2 to 20 years: Boys

#### Stature-for-age and Weight-for-age percentiles

<table>
<thead>
<tr>
<th>Name</th>
<th>Record #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SOURCE:** Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).

Published May 30, 2000 (modified 11/21/00).

http://www.cdc.gov/growthcharts

---

**Mother's Stature**

**Father's Stature**

<table>
<thead>
<tr>
<th>Date</th>
<th>Age</th>
<th>Weight</th>
<th>Stature</th>
<th>BMI*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*To Calculate BMI: Weight (kg) ÷ Stature (cm) ÷ Stature (cm) x 10,000

or Weight (lb) ÷ Stature (in) ÷ Stature (in) ÷ 703
# Maryland Healthy Kids Program
## Medical/Family History Questionnaire

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Date of Birth:</th>
<th>Sex: (circle)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Male       Female</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Form Completed By:</th>
<th>Today’s Date</th>
<th>Relationship:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## PREGNANCY AND BIRTH HISTORY

<table>
<thead>
<tr>
<th>Name of Hospital:</th>
<th>Illnesses during pregnancy?</th>
<th>No ☐ Yes ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Medications during pregnancy?</td>
<td>No ☐ Yes ☐</td>
</tr>
<tr>
<td></td>
<td>Alcohol/Drug Abuse?</td>
<td>No ☐ Yes ☐</td>
</tr>
<tr>
<td></td>
<td>Problems at birth?</td>
<td>No ☐ Yes ☐</td>
</tr>
</tbody>
</table>

Describe: ________________________________

<table>
<thead>
<tr>
<th>Type of delivery?</th>
<th>Vaginal</th>
<th>C-section</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth Weight</td>
<td>Discharge Weight</td>
<td></td>
</tr>
</tbody>
</table>

Did baby receive Hepatitis B vaccine? | No ☐ Yes ☐ |

Date of Hepatitis B immunization: __________________________

Newborn Hearing Screen? | No ☐ Yes ☐ |

## PSYCHOSOCIAL HISTORY

Who lives in household? ________________________________

How many? ____________________________

<table>
<thead>
<tr>
<th>Rent?</th>
<th>Own?</th>
<th>Shelter?</th>
</tr>
</thead>
</table>

Who cares for child? ________________________________

Date of Birth? | Mother | Father |
|---------------|-------|-------|

Are parents working? | Mother No ☐ Yes ☐ | Father No ☐ Yes ☐ |

Foster Care? | Dates: ____________________________

Other Languages? ________________________________

## FAMILY HISTORY

Has anyone in the family (parents, grand-parents, aunts/uncles, sisters/brothers) had:

<table>
<thead>
<tr>
<th>Allergies (List)</th>
<th>No ☐ Yes ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>No ☐ Yes ☐</td>
</tr>
<tr>
<td>TB/Lung Disease</td>
<td>No ☐ Yes ☐</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>No ☐ Yes ☐</td>
</tr>
<tr>
<td>Suicide Attempts</td>
<td>No ☐ Yes ☐</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>No ☐ Yes ☐</td>
</tr>
<tr>
<td>High Blood Pressure/Stroke</td>
<td>No ☐ Yes ☐</td>
</tr>
<tr>
<td>High Cholesterol</td>
<td>No ☐ Yes ☐</td>
</tr>
<tr>
<td>Blood Disorders/Sickle Cell</td>
<td>No ☐ Yes ☐</td>
</tr>
<tr>
<td>Diabetes</td>
<td>No ☐ Yes ☐</td>
</tr>
<tr>
<td>Seizures</td>
<td>No ☐ Yes ☐</td>
</tr>
<tr>
<td>Mental Illness</td>
<td>No ☐ Yes ☐</td>
</tr>
<tr>
<td>Cancer</td>
<td>No ☐ Yes ☐</td>
</tr>
<tr>
<td>Birth Defects</td>
<td>No ☐ Yes ☐</td>
</tr>
<tr>
<td>Hearing Loss</td>
<td>No ☐ Yes ☐</td>
</tr>
<tr>
<td>Speech Problems</td>
<td>No ☐ Yes ☐</td>
</tr>
<tr>
<td>Kidney Disease</td>
<td>No ☐ Yes ☐</td>
</tr>
<tr>
<td>Alcohol/Drug Abuse</td>
<td>No ☐ Yes ☐</td>
</tr>
<tr>
<td>Hepatitis/Liver Disease</td>
<td>No ☐ Yes ☐</td>
</tr>
<tr>
<td>Thyroid Disease</td>
<td>No ☐ Yes ☐</td>
</tr>
<tr>
<td>Learning Problems/Attention</td>
<td>No ☐ Yes ☐</td>
</tr>
<tr>
<td>Deficit Disorder</td>
<td>No ☐ Yes ☐</td>
</tr>
<tr>
<td>Family Violence</td>
<td>No ☐ Yes ☐</td>
</tr>
</tbody>
</table>

Other: ________________________________

## MEDICAL HISTORY

Has your child ever had:

<table>
<thead>
<tr>
<th>Allergies (List)</th>
<th>No ☐ Yes ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>No ☐ Yes ☐</td>
</tr>
<tr>
<td>Chicken Pox (Year)</td>
<td>No ☐ Yes ☐</td>
</tr>
<tr>
<td>Frequent Ear Infections</td>
<td>No ☐ Yes ☐</td>
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<tr>
<td>Vision/Hearing Problems</td>
<td>No ☐ Yes ☐</td>
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<tr>
<td>Skin Problems/Eczema</td>
<td>No ☐ Yes ☐</td>
</tr>
<tr>
<td>TB/Lung Disease</td>
<td>No ☐ Yes ☐</td>
</tr>
<tr>
<td>Seizures/Epilepsy</td>
<td>No ☐ Yes ☐</td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td>No ☐ Yes ☐</td>
</tr>
<tr>
<td>Heart Defects/Disease</td>
<td>No ☐ Yes ☐</td>
</tr>
<tr>
<td>Liver Disease/Hepatitis</td>
<td>No ☐ Yes ☐</td>
</tr>
<tr>
<td>Diabetes</td>
<td>No ☐ Yes ☐</td>
</tr>
<tr>
<td>Kidney Disease/Bladder Infections</td>
<td>No ☐ Yes ☐</td>
</tr>
<tr>
<td>Physical or Learning Disabilities</td>
<td>No ☐ Yes ☐</td>
</tr>
<tr>
<td>Bleeding Disorders/Hemophilia</td>
<td>No ☐ Yes ☐</td>
</tr>
<tr>
<td>Sexually Transmitted Diseases</td>
<td>No ☐ Yes ☐</td>
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<tr>
<td>Emotional or Behavioral Problems</td>
<td>No ☐ Yes ☐</td>
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<tr>
<td>Depression/Suicidal Thoughts</td>
<td>No ☐ Yes ☐</td>
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<tr>
<td>Hospitalizations/Surgeries</td>
<td>No ☐ Yes ☐</td>
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<tr>
<td>Physical/Emotional/Sexual Abuse</td>
<td>No ☐ Yes ☐</td>
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<tr>
<td>Bone or Joint Injuries</td>
<td>No ☐ Yes ☐</td>
</tr>
<tr>
<td>Obesity/Eating Disorders</td>
<td>No ☐ Yes ☐</td>
</tr>
</tbody>
</table>

Other: ________________________________

Current Medication(s): (List) ________________________________

Reviewed by: __________________ Date of Review: __________________
### Cuestionario de Historial Médico Familiar

<table>
<thead>
<tr>
<th>Nombre del Paciente:</th>
<th>Fecha de Nacimiento:</th>
<th>Sexo:</th>
<th>M</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persona que llenó el Formulario:</td>
<td>Fecha de Hoy:</td>
<td>Relación con el Paciente:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### HISTORIAL DURANTE EMBARAZO Y AL NACER

<table>
<thead>
<tr>
<th>Nombre del Hospital:</th>
<th>¿Quién vive en el hogar?</th>
</tr>
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<tbody>
<tr>
<td>Enfermedades durante el embarazo:</td>
<td></td>
</tr>
<tr>
<td>Medicamentos durante el embarazo:</td>
<td>No</td>
</tr>
<tr>
<td>Abuso de Alcohol o drogas:</td>
<td>No</td>
</tr>
<tr>
<td>Problemas al Nacer:</td>
<td>No</td>
</tr>
<tr>
<td>Describa:</td>
<td></td>
</tr>
<tr>
<td>Tipo de Parto:</td>
<td>Vaginal</td>
</tr>
<tr>
<td>Peso al Nacer</td>
<td></td>
</tr>
<tr>
<td>El bebé recibió vacuna para Hepatitis B:</td>
<td>No</td>
</tr>
<tr>
<td>Fecha de la vacuna de Hepatitis B:</td>
<td></td>
</tr>
<tr>
<td>Examen Auditivo para recién nacidos:</td>
<td>No</td>
</tr>
</tbody>
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#### HISTORIAL FAMILIAR

<table>
<thead>
<tr>
<th>Hay alguien en la familia (padres, abuelos, tíos/as, hermanos/as) que haya tenido:</th>
<th>Alguna vez su niño/a ha tenido:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alergias (a qué)</td>
<td>¿Quién?</td>
</tr>
<tr>
<td>Asma</td>
<td>No</td>
</tr>
<tr>
<td>TB/Enfermedad del Pulmón</td>
<td>No</td>
</tr>
<tr>
<td>VIH/SIDA</td>
<td>No</td>
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<td>Intentos Suicidas/Problemas</td>
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<tr>
<td>Mentales</td>
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<td>Enfermedad del Corazón</td>
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<td>Presión alta/Derrame</td>
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<td>Colesterol Alto</td>
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<td>Desórdenes de la</td>
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<tr>
<td>Sangre/&quot;Sickle Cell&quot;</td>
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<tr>
<td>Diabetes</td>
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<tr>
<td>Convulsiones</td>
<td>No</td>
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<tr>
<td>Alergias/Asma</td>
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<tr>
<td>Desórdenes Mentales</td>
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<tr>
<td>Cáncer</td>
<td>No</td>
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<tr>
<td>Defectos de Nacimiento</td>
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<td>Pérdida de Audición</td>
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<td>Problemas de habla</td>
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<td>Enfermedades Raciales</td>
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<tr>
<td>Abuso de Alcohol/ Drogas</td>
<td>No</td>
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<tr>
<td>Hepatitis/Enfermedad del</td>
<td>No</td>
</tr>
<tr>
<td>Hígado</td>
<td>No</td>
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<tr>
<td>Enfermedad de la Tiroides</td>
<td>No</td>
</tr>
<tr>
<td>Problemas de Aprendizaje/</td>
<td>No</td>
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<tr>
<td>Deficit de Atención (&quot;ADD&quot;)</td>
<td>No</td>
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<tr>
<td>Violencia Doméstica</td>
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<tr>
<td>Otras:</td>
<td></td>
</tr>
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</table>

#### HISTORIAL PSICOSOCIAL

<table>
<thead>
<tr>
<th>¿Quién cuida el niño/a?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alguien en la familia (padres, abuelos, tíos/as, hermanos/as) que haya tenido:</td>
</tr>
<tr>
<td>Alergias (a qué)</td>
</tr>
<tr>
<td>Alguna vez su niño/a ha tenido:</td>
</tr>
<tr>
<td>Asma</td>
</tr>
<tr>
<td>Varicela (año)</td>
</tr>
<tr>
<td>Infecciones frecuentes de la vista</td>
</tr>
<tr>
<td>Varicela</td>
</tr>
<tr>
<td>Problemas de la Piel/Eczema</td>
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<td>Asma/Alergias</td>
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<tr>
<td>TB/Enfermedad del Pulmón</td>
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<tr>
<td>Convulsiones/Epilepsia</td>
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<tr>
<td>Hipertensión/Presión Alta</td>
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<tr>
<td>Enfermedad del Corazón/Defectos</td>
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<tr>
<td>Diabetes</td>
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<tr>
<td>Enfermedades del Riñón/Vejiga</td>
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<tr>
<td>Enfermedades Físicas o de Aprendizaje</td>
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<td>Desórdenes de la Sangre/Hemofilia</td>
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<td>Problemas Emocionales o de Comportamiento</td>
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<td>Depresión/Pensamientos Suicidas</td>
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<td>Problemas en las Coyunturas/Huesos</td>
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<td>Obesidad/Trastornos Alimenticios</td>
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#### HISTORIAL DE SALUD

| Lista de Medicamento/s que toma: |

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**Revisado por:**

**Fecha que fue Revisado:**

Updated: 4/06
## OBJECTIVE HEARING AND VISION TESTING

**MARYLAND HEALTHY KIDS PROGRAM**

Child’s Name: ___________________________________  Date of Birth__________

**Objective Vision Testing recommended at ages 3 to 6, 8, 10, 12, 15, and 18 years**

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<thead>
<tr>
<th>Ages 3 – 6</th>
<th>Ages 8 – 20</th>
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<td><strong>Visual Acuity</strong></td>
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<tr>
<td>R _____     L _____</td>
<td>R _____     L _____</td>
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<tr>
<td>Near R _____     L _____</td>
<td>Near R _____     L _____</td>
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<tr>
<td>Far  R _____     L _____</td>
<td>Far  R _____     L _____</td>
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<td><strong>Vision Fusion:</strong></td>
<td><strong>Hyperopia:</strong></td>
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<tr>
<td>Pass _____     Fail _____</td>
<td>Pass _____     Fail _____</td>
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<tr>
<td><strong>Color Screens (optional):</strong></td>
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**Objective Hearing Testing recommended at ages 3 to 6, 8, 10, 12, 15, and 18 years**

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