## PHYSICAL EXAMINATION

(choose appropriate box):

- **N L** (normal)
- **AB** (abnormal)
- **NE** (not examined)

### General

- Skin

### Eyes

- Red reflex, appearance

### Ears, TMs

### Nose

### Lips/Palate

### Tongue/Pharynx

### Neck/Nodes

### Chest/Breast

### Lungs

### Heart

### Abd/Umbilicus

### Genitalia/ Femoral Pulses

### Extremities, Clavicles, Hips

### Muscular

### Neuromotor

### Back/Sacral Dimple

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### HISTORY:

**Parent Concerns:**

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**Initial/Interval History:**

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**FSH:**

- FSH form reviewed (check other topics discussed):
  - Daily care provided by
  - Parent
  - Other:

**Adequate support system?**

- Yes
- No

**Adequate respite?**

- Yes
- No

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### DEVELOPMENTAL/BEHAVIORAL ASSESSMENT:

**Parent Concerns Discussed? (Required)**

- Yes

**Standardized Screen Used? (Suggested by AAP)**

- Yes
- No

**See instrument form:**

- PEDS
- Ages & Stages
- Other:

**DB Concerns:**

- (e.g. sleep/feeding)

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**Clinician Observations/History:**

(Suggested options)

- **Motor Skills** (observe head, trunk, and limb control)
  - Walks up stairs
  - Y N

- **Fine Motor Skills**
  - Uses spoon
  - Y N
  - Scribbles spontaneously
  - Y N

- **Language/Socioemotional/Cognitive Skills**
  - Mature jargon (mumbles with inflection)
  - Y N
  - Understands 1-step command without gesture
  - (16mos)
  - Y N
  - Points to one or more body parts
  - Y N
  - Cooperates while dressing
  - Y N
  - Likes to be with other children
  - Y N
  - Pretend play
  - Y N
  - Waves (red flag)
  - Y N
  - Points (red flag)
  - Y N
  - Plays peek-a-boo (red flag)
  - Y N

- **Parent – Infant Interaction**
  - Interaction appears age appropriate
  - Y N

**Clinician concerns regarding interaction:**

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**SENSORY SCREENING:**

- Any parent concerns about vision or hearing?
  - Yes
  - No

**Vision:**

- Follows objects and eyes team together:
  - Yes
  - No

**Hearing:**

- Responds to sounds:
  - Yes
  - No

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OHCA Revised 03/13/2014 CH-9
(EPSDT) 30-Month Visit Page 2

NAME: ___________________ DOB: __________
MED RECORD #: ___________________ DOV: ________

ANTICIPATORY GUIDANCE:
Select at least one topic in each category (as appropriate to family):

Injury/Serious Illness Prevention:
- Car Seat
- Falls
- No strings around neck
- No shaking
- Burns-hot water heater max temp 125 degrees F
- Smoke alarms
- No passive smoke (Oklahoma Tobacco Helpline: 1.800.QUIT.NOW)
- Sun protection
- Walkers
- Hanging cords
- Fever management
Other: ___________________________

Violence Prevention:
- Adequate support system?
- Adequate respite?
- Feel safe in neighborhood?
- Domestic Violence?
- No Shaking
- Gun Safety
Other: ___________________________

Sleep Safety Counseling:
- Sleep Safety
- Read to infant (e.g. Reach out and Read)
Other: ___________________________

Nutrition Counseling:
- Whole cow’s milk until 2 yrs
- Limit juice (4 oz or less/day)
- Feeding self solids/finger foods
- Vitamins
- No popcorn, peanuts, hard candy
Other: ___________________________

What to anticipate before next visit:
- May want more independence (especially in feeding)
- Variable appetite
- Child-proofing
- Discipline
- Help child learn self-control skills (e.g., not interrupting, not fighting with siblings)
- Different rates of development are normal
- Establish routines
- Offer simple choices
- For a sense of security, provide familiar objects for comfort
Other: ___________________________

PROCEDURES:
- Hematocrit of Hemoglobin
- TB test
- Blood lead test

DENTAL REMINDER
- PCP screen until 3
- Fluoride source?

IMMUNIZATIONS DUE at this visit:

HepA2 # ________
- Given
- Not Given
- Up to Date

Flu (yearly)
- Given
- Not Given
- Up to Date

Date Flu previously given: ___________________________

Catch-up on vaccines

HepB # ________
- Given
- Not Given
- Up to Date

DTap # ________
- Given
- Not Given
- Up to Date

Hib # ________
- Given
- Not Given
- Up to Date

IPV # ________
- Given
- Not Given
- Up to Date

PCV # ________
- Given
- Not Given
- Up to Date

MMRV # ________
- Given
- Not Given
- Up to Date

Reason Not Given if due: List Vaccine(s) not given:

Vaccine not available: ___________________________
Child ill: ___________________________
Parent Declined: ___________________________
Other: ___________________________

NOTE: See 9 month form if child’s mother was HEPBsAg positive

ASSESSMENT: ☐ Healthy, no problems

PLAN/RECOMMENDATIONS:
- Do vaccines/procedures marked above
- Other: ___________________________
- Anticipatory guidance discussed (as described in box above)

Next Health Supervision (EPSDT) Visit Due: ___________________________
Provider Signature: ___________________________ Date: ___________________________