### PHYSICAL EXAMINATION (check appropriate box):

<table>
<thead>
<tr>
<th>NL</th>
<th>AB</th>
<th>NE</th>
<th>COMMENTS</th>
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</thead>
<tbody>
<tr>
<td>General</td>
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<tr>
<td>Skin</td>
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<td>Fontanels</td>
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<tr>
<td>Eyes: Red Reflex, Appearance</td>
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<td>Ears, TMs</td>
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<td>Nose</td>
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<td>Lips/Palate</td>
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<td>Teeth/Gums</td>
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<td>Tongue/Pharynx</td>
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<td>Neck/Nodes</td>
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<td>Chest/Breast</td>
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<td>Lungs</td>
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<td>Heart</td>
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<td>Abd/Umbilicus</td>
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<td>Genitalia/ Femoral Pulses</td>
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<td>Extremities, Clavicles, Hips</td>
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<td>Muscular</td>
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<td>Neuromotor</td>
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<tr>
<td>Back/Sacral Dimple</td>
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</table>

**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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### 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 □ Daycare □ 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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### MOTOR SKILLS (observe head, trunk, and limb control)

- Walks independently □ Y □ N
- Creeps/crawls up stairs □ Y □ N

### FINE MOTOR SKILLS

- Feed self, drinks from cup □ Y □ N
- Scribbles spontaneously □ Y □ N

### LANGUAGE/SOCIOEMOTIONAL/COGNITIVE SKILLS

- Says 3-6 words □ Y □ N
- Understands simple commands □ Y □ N
- Listens to a story □ Y □ N
- Points to one or more body parts □ Y □ N
- Cooperates while dressing □ 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

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### CLINICIAN OBSERVATIONS/HISTORY: (Suggested options)

**Clinician Concerns regarding interaction:**

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

#### What to anticipate before next visit:
- May want more independence (especially in feeding)
- Variable appetite
- Okay to allow infant to finger feed
- Child-proofing
- Discipline
- Different rates of development are normal
- Other:__________________________

### PROCEDURES:
- Blood lead test (if not previously tested)
- TB test (if at risk)

### DENTAL REMINDER
PCP screen at 1st tooth eruption
- Fluoride source?

### IMMUNIZATIONS DUE at this visit:
- Flu (yearly)
- 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
  - Hep A #________
    - Given
    - Not Given
    - Up to Date

#### Reason Not Given if due:
- Vaccines 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: ______________________