



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

Parents working outside home? Mother Father
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
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 the Medical Necessity Form 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

