

Screen Date \_\_\_\_\_

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

Weight \_\_\_\_\_ Length \_\_\_\_\_ Weight for Length \_\_\_\_\_ HC \_\_\_\_\_ Pulse \_\_\_\_\_ BP (optional) \_\_\_\_\_ Resp \_\_\_\_\_ Temp \_\_\_\_\_ Pulse Ox (optional) \_\_\_\_\_

Allergies  NKDA \_\_\_\_\_

Current meds  None \_\_\_\_\_

Foster child \_\_\_\_\_  Kinship placement \_\_\_\_\_  Child with special health care needs \_\_\_\_\_

Accompanied by  Parent  Grandparent  Foster parent  Foster organization \_\_\_\_\_  Other \_\_\_\_\_

**Medical History**

Initial screen  Periodic screen

Family health history reviewed \_\_\_\_\_

Parental history of postpartum depression  Yes  No

In utero substance exposure  Yes  No \_\_\_\_\_

Maternal Hep C exposure  Yes  No \_\_\_\_\_

Child recent injuries, surgeries, illnesses, visits to other providers and/or hospitalizations: \_\_\_\_\_

**Psychosocial/Behavioral**

What is your family's living situation? \_\_\_\_\_

Family relationships  Good  Okay  Poor

Do you have the things you need to take care of your baby (crib, car seat, diapers, etc.)?  Yes  No \_\_\_\_\_

Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)?  Yes  No \_\_\_\_\_

Who do you contact for help and/or support? \_\_\_\_\_

Are you and/or your partner working outside home?  Yes  No

Child care \_\_\_\_\_

Child exposed to  Cigarettes  E-Cigarettes/Vaping  Alcohol

Drugs (prescription or otherwise) \_\_\_\_\_

Access to firearm(s)/weapon(s)

Are the firearm(s)/weapon(s) secured?  Yes  No  NA

Witnessed violence/abuse  Threatened with violence/abuse

Scary experience that your child cannot forget \_\_\_\_\_

How much **stress** are you and your family under **now**?

None  Slight  Moderate  Severe

**What kind of stress?** (✓ Check those that apply)

Relationships (partner, family and/or friends)  School/work

Child care  Drugs  Alcohol  Violence/abuse (physical, emotional and/or sexual)  Family member incarcerated  Lack of support/help  Financial/money  Emotional loss  Health insurance  Other \_\_\_\_\_

Does your child seem nervous or afraid?

Not at all  Somewhat  Very much

Does your child seem sad or unhappy?

Not at all  Somewhat  Very much

Does your child get upset when things are not done a certain way?

Not at all  Somewhat  Very much

Does your child have a hard time with change?

Not at all  Somewhat  Very much

Does your child break things on purpose?

Not at all  Somewhat  Very much

Does your child have a hard time calming down?

Not at all  Somewhat  Very much

Is your child aggressive?

Not at all  Somewhat  Very much

Is it hard to take your child out in public?

Not at all  Somewhat  Very much

**Developmental**

Developmental surveillance and screening completed with Standardized Screening Tool

ASQ3  Other tool \_\_\_\_\_

Results in child's record  Yes  No

Autism screening completed with an Autism Specific Tool

M-CHAT-R/F  Other tool \_\_\_\_\_

Results in child's record  Yes  No

**General Health**

Growth plotted on growth chart

Do you think your child sees okay?  Yes  No

Do you think your child hears okay?  Yes  No

**Oral Health**

Date of last dental visit \_\_\_\_\_

Current oral health problems \_\_\_\_\_

Water source  Public  Well  Tested

Fluoride supplementation  Yes  No

Fluoride varnish applied (apply every 3 to 6 months)

Yes  No \_\_\_\_\_

**Nutrition/Sleep**

Breastfeeding - Frequency \_\_\_\_\_

Bottle feeding - Amount \_\_\_\_\_ Frequency \_\_\_\_\_

Formula \_\_\_\_\_

Plans for weaning \_\_\_\_\_

Milk  Juice  Water

Normal eating habits

Vitamins

Normal elimination \_\_\_\_\_

Normal sleeping patterns \_\_\_\_\_

Hours of sleep each night? \_\_\_\_\_

Continue on page 2

