RED MOUNTAIN
FAMILY SERVICES, INC.

EPSDT Exam

Medical Facility:	Date:
Address:	Name of Client:
Physician:	Date of Birth:

Comprehensive Assessment

Physical Exam: Temp:_____ HR:_____ Resp:_____ O2sat:_____ BP:_____ Wt:_____ %:_____

Ht:_____ %:_____ Head Circumference:_____ %:_____

Hearing:_____ Vision:_____ Allergies:_____

Laboratory Studies: Hematocrit:_____ % Lead:_____ Hepatitis Panel:_____

Immunizations: Up-to-date: Yes:_____ No:_____ Current Medications: _____

General Appearance/Mood/Hygiene:

General Appearance	**Normal For Age**	**Abnormal**	**Relevant Information (from health history, parent/teacher, observations, etc.)**
Skin			
Head Shape			
Nose/Mouth/Throat			
Teeth			
Ears			
(1) External			
(2) Tympanic Membranes			
Eyes			
Lungs			
Heart			
Abdomen			
Genitalia			
Menstruation (Female)			
Neurological			
Muscular Coordination			
Bones/Joints/Muscles			
Glands, Lymphatic, Thyroid			

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General Statement of Abnormal Findings

_____

_____

_____

_____

Neurological/Social:

	Normal For Age	Abnormal	General Statement of Abnormal Findings:
Gross Motor			
Posture/Gait			
Fine Motor			
Communication Skills			
Cognitive			
Self-Help Skills			
Social Skills			
Speech			

_____

Physician Signature Date