

EARLY AND PERIODIC SCREENING DIAGNOSIS AND TREATMENT PERIODICITY SCHEDULE

AGE	By 1	2	4	6	9	12	15	18	24	3	4	5	7	9	11	13	15	17	19	20	
	Mo.	Mo.	Mo.	Mo.	Mo.	Mo.	Mo.	Mo.	Mo.	Yr.											
HISTORY																					
Initial/Interval	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
MEASUREMENTS																					
Height & Weight	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Head Circumference	*	*	*	*	*	*															
Blood Pressure										*	*	*	*	*	*	*	*	*	*	*	*
SENSORY SCREENING																					
Vision	S	S	S	S	S	S	S	S	S	S	O	O	O	O	S	O	O	S	O	O	O
Hearing	S	S	S	S	S	S	S	S	S	S	O	O	S	S	S	O	S	S	O	S	S
DEVELOPMENT/ BEHAVIORAL ASSESSMENT	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
PHYSICAL EXAMINATION	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
PROCEDURES																					
Hereditary/Metabolic Screening	*																				
Immunization		*	*	*			*	*	*			*					*				
Tuberculin Test						*			*										*		
Hematocrit or Hemoglobin						*			*					*					*		
Urinalysis				*					*					*					*		
ANTICIPATORY GUIDANCE	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
INITIAL DENTAL Referral						*			*										*		
BLOOD LEAD SCREEN						*			*										*		

KEY: * to be performed
 s subjective, by history
 o objective, by a standard testing method

Please note that Blood Lead Screenings must be performed at 12 and 24 months