NAME:	MEDICAID ID:
DOB:	PRIMARY CARE GIVER:
GENDER: ☐ MALE ☐ FEMALE	PHONE:
DATE OF SERVICE:	INFORMANT:

Texas Health Steps

CHILD HEALTH RECORD

4 YEAR CHECKUP

HISTORY

☐ See new patient history form

INTERVAL HISTORY:
☐ NKDA Allergies:

Current Medications:

Visits to other health-care providers, facilities:

Parental concerns/changes/stressors in family or home:

Psychosocial/Behavioral Health Issues: Y ☐ N ☐
Findings:

TB questionnaire*, risk identified: Y N
**Tuberculin Skin Test if indicated* TST
(See back for form)

DEVELOPMENTAL SCREENING:
Use of standardized tool:
ASQ ☐ ASQ:SE ☐ PEDS ☐ P F

NUTRITION*:
Problems: Y N
Assessment:

**See Bright Futures Nutrition Book if needed*

IMMUNIZATIONS

☐ Up-to-date
☐ Deferred - Reason:

Given today: ☐ DTaP ☐ Hep A ☐ Hep B ☐ Hib ☐ IPV
☐ Meningococcal* ☐ MMR ☐ Pneumococcal*
☐ Varicella ☐ MMRV ☐ DTaP-IPV
☐ DTaP-IPV-Hep B ☐ DTaP-IPV/Hib ☐ Influenza

**Special populations: See ACIP*

LABORATORY

UNCLOTHED PHYSICAL EXAM

☐ See growth graph

Weight: _____ (_____%) Height: _____ (_____%)
BMI: _____ (_____%) Heart Rate: _____
Blood Pressure: _____/_____ Respiratory Rate: _____
Temperature (optional): _____

☐ Normal (Mark here if all items are WNL)

Abnormal (Mark all that apply and describe):

☐ Appearance	☐ Nose	☐ Lungs
☐ Head	☐ Mouth/throat	☐ GI/abdomen
☐ Skin	☐ Teeth	☐ Extremities
☐ Eyes	☐ Neck	☐ Back
☐ Ears	☐ Heart	☐ Musculoskeletal
		☐ Neurological

Abnormal findings:

Audiometric Screening:
R 1000Hz_____ 2000HZ_____ 4000HZ_____
L 1000Hz_____ 2000HZ_____ 4000HZ_____

Visual Acuity Screening:
OD____/____ OS____/____ OU____/____

HEALTH EDUCATION/ANTICIPATORY GUIDANCE *(See back for useful topics)*

☐ Selected health topics addressed in any of the following areas*:

- School Readiness/Limitations
- Nutrition
- Personal Hygiene
- Safety

**See Bright Futures for assistance*

ASSESSMENT

PLAN/REFERRALS

Dental Referral: Y ☐
Other Referral(s)

Return to office:

Signature/title

Signature/title

Texas Health Steps

CHILD HEALTH RECORD

4 YEAR CHECKUP

Name: | Medicaid ID:

Typical Developmentally Appropriate Health Education Topics

4 Year Old Checkup

- Lead risk assessment*
- Encourage child to tell the story his/her way
- Establish consistent family routine
- Establish daily chores to develop sense of accomplishment and self-confidence
- Limit TV/computer time to 1-2 hours/day
- Show affection/praise for good behaviors
- Provide nutritious 3 meals and 2 snacks; limit sweets/sodas/high-fat foods
- Establish routine and assist with tooth brushing with soft brush twice a day
- Develop a family plan for exiting house in a fire/establish meeting place after exit
- Lock up guns
- No shaking baby (Shaken Baby Syndrome)
- Provide home safety for fire/carbon monoxide poisoning
- Provide safe/quality after-school care
- Supervise when near or in water even if child knows how to swim
- Teach child parents' names/home address/telephone numbers
- Teach how to answer the door/ telephone
- Teach self-safety for personal privacy
- Teach street safety/running after balls/do not cross alone
- Use of booster seat in back seat of car if 40 pounds, until 4ft 9in or 8 years old
- Encourage constructive conflict resolution, demonstrate at home
- Encourage self-dressing and allow to choose own clothing at times
- Encourage supervised outdoor play for 1 hour/day
- Establish consistent bedtime routine
- Establish consistent limits/rules and consistent consequences
- If in pre-school, advocate with teacher for child with school difficulties/bullying
- Read and discuss story daily

TB QUESTIONNAIRE

Place a mark in the appropriate box:	**Yes**	**Do not know**	**No**
Has your child been tested for TB?	☐	☐	☐
If yes, when (date)			
Has your child ever had a positive Tuberculin Skin Test?	☐	☐	☐
If yes, when (date)			
TB can cause fever that lasts for days or weeks, unexplained weight loss, a bad cough (lasting over two weeks), or coughing up blood. As far as you know:			
has your child been around anyone with any of these symptoms or problems?	☐	☐	☐
has your child been around anyone sick with TB?	☐	☐	☐
has your child had any of these symptoms or problems?	☐	☐	☐
Was your child born in Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe, or Asia?	☐	☐	☐
Has your child traveled in the past year to Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe, or Asia for longer than 3 weeks?	☐	☐	☐
If so, specify which country/countries?			
To your knowledge, has your child spent time (longer than 3 weeks) with anyone who is/has been an intravenous (IV) drug user, HIV-infected, in jail or prison, or has recently come to the United States from another country?	☐	☐	☐

*LEAD RISK FACTORS

Perform a blood lead test if parent/caretaker answers "Yes/Don't Know" to any of the questions below.	**Yes**	**Don't know**	**No**
• Child lives in or visits a home, day care, or other building built before 1978 or undergoing repair	☐	☐	☐
• Pica (Eats non-food items)	☐	☐	☐
• Family member with an elevated blood lead level	☐	☐	☐
• Child is a newly arrived refugee or foreign adoptee	☐	☐	☐
• Exposure to an adult with hobbies or jobs that may have risk of lead contamination (See Pb-110 for a list)	☐	☐	☐
• Food sources (including candy) or remedies (See Pb-110 for a list)	☐	☐	☐
• Imported or glazed pottery	☐	☐	☐
• Cosmetics that may contain lead (See Pb-110 for a list)	☐	☐	☐

The use of the Form Pb-110, Lead Risk Questionnaire is optional. It is available at www.dshs.state.tx.us/thsteps/forms.shtm. If completed, return the form to the Texas Childhood Lead Poisoning Prevention Program as directed on the form.