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

Texas Health Steps

12 MONTH CHECKUP CHILD HEALTH RECORD

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 SURVEILLANCE:**
- Gross and fine motor development
- Communication skills/language development
- Self-help/care skills
- Social, emotional development
- Cognitive development
- Mental health

NUTRITION*:
☐ Breastmilk
Min per feeding: _____ Number of feedings in last 24 hrs: _____
☐ Formula (type) _____
Oz per feeding: _____ Number of feedings in last 24 hrs: _____
Water source: _____ fluoride: Y ☐ N ☐
☐ Solids _____

**See Bright Futures Nutrition Book if needed*

IMMUNIZATIONS

☐ Up-to-date
☐ Deferred - Reason:

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

**Special populations: See ACIP*

LABORATORY

Tests ordered today:
Hgb/Hct: Y ☐ N ☐
Blood lead test: Y ☐ N ☐
Other: _____

Signature/title

UNCLOTHED PHYSICAL EXAM

☐ See growth graph

Weight: _____ (_____%) Length: _____ (_____%)
Head Circumference: _____ (_____%)
Heart Rate: _____ Respiratory Rate: _____
Temperature (optional): _____

☐ Normal (Mark here if all items are WNL)

Abnormal (Mark all that apply and describe):

☐ Appearance	☐ Mouth/throat	☐ Genitalia
☐ Head/fontanels	☐ Teeth	☐ Extremities
☐ Skin	☐ Neck	☐ Back
☐ Eyes	☐ Heart/pulses	☐ Musculoskeletal
☐ Ears	☐ Lungs	☐ Hips
☐ Nose	☐ Abdomen	☐ Neurological

Abnormal findings:

Subjective Vision Screening: P ☐ F ☐
Subjective Hearing Screening: P ☐ F ☐

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

☐ Selected health topics addressed in any of the following areas*:
- Family Interactions
- Nutrition
- Setting Routines
- Safety
- Development/Behaviors

**See Bright Futures for assistance*

ASSESSMENT

PLAN/REFERRALS

Dental Referral: Y ☐
Other Referral(s)

Return to office:

Signature/title

Texas Health Steps

CHILD HEALTH RECORD

12 MONTH CHECKUP

Name: | Medicaid ID:

Typical Developmentally Appropriate Health Education Topics

12 Month Checkup

- Begin weaning from bottle/breast to cup
- Discipline constructively using time-out for 1 minute/ year of age
- Encourage supervised outdoor play
- Establish consistent limits/rules and consistent consequences
- Limit TV time to 1-2 hours/day
- Praise good behavior
- Promote language using simple words
- Provide age-appropriate toys
- Provide favorite toy for self-soothing during sleep time
- Read books and talk about pictures/story using simple words
- Use distraction or choice of 2 appropriate options to avoid/resolve conflicts
- Make 1:1 time for each child in family
- No bottle in bed
- Provide nutritious 3 meals and 2 snacks; limit sweets/ high-fat foods
- Empty all buckets containing water
- Home safety for fire/carbon monoxide poisoning, stair/window gates, electrical outlet covers, cleaning supplies, and medicines out of reach
- Lock up guns
- Provide safe/quality day care, if needed
- Supervise within arm's length when near water/do not leave alone in bath water
- Use of front-facing car seat in back seat of car if >20 pounds
- Establish consistent bedtime routine
- Establish routine and assist with tooth brushing with soft brush twice a day
- Maintain consistent family routine
- Provide nap time 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?	☐	☐	☐

HEARING CHECKLIST FOR PARENTS (OPTIONAL)

	Yes	**No**	
Ages 9 to 12 months	☐	☐	Points to or looks at familiar objects or people when asked to
	☐	☐	Looks sad when scolded
	☐	☐	Follows directions ("Open your mouth," "Give me the ball")
	☐	☐	Dances and makes sounds to music
	☐	☐	Uses jargon (appears to be talking)
	☐	☐	Uses consonant sounds like b, d, g, m, and n when talking
	☐	☐	Jabbers in response to a human voice, changes loudness of voice, and uses rhythm and tone

EARLY CHILDHOOD INTERVENTION (ECI)

The ECI referral form is available at:
http://txpeds.org/sites/txpeds.org/files/documents/ECI-Referral-Form.pdf