| | |
|---|---|
| NAME: | MEDICAID ID: |
| DOB: | PRIMARY CARE GIVER: |
| GENDER: | PHONE: |
| DATE OF SERVICE: | INFORMANT: |

Texas Health Steps

# CHILD HEALTH RECORD

# 10 YEAR VISIT

## 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 ☐
**TB skin test if indicated* ☐ PPD placed
*(See back for form)*

**NUTRITION*:**
Problems: Y ☐ N ☐
Assessment:

**See Bright Futures Nutrition Book if needed*

## IMMUNIZATIONS

☐ Up-to-date
☐ Deferred - Reason:

Given today: ☐ HAV ☐ HBV ☐ HPV ☐ IPV
☐ TD/TdaP ☐ Meningococcal ☐ MMR
☐ MMR-V ☐ Pneumococcal ☐ Varicella ☐ Influenza

## LABORATORY

☐ Up-to-date
☐ Deferred - Reason:

Ordered today:

## UNCLOTHED PHYSICAL EXAM

☐ See growth graph

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

☐ 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 | ☐ Neurological | ☐ Back |
| ☐ Ears | ☐ Heart | ☐ Musculoskeletal |

Abnormal findings:

Additional:
Breasts _____/5 Genitalia _____/5

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 Performance
- Physical Activity
- Development and Mental Health
- Nutrition
- Oral Health
- Safety

## ASSESSMENT

## PLAN/REFERRALS

Dental Referral: Y ☐
Other Referral(s)

Return to office:

Signature/title

Signature/title

Name: Medicaid ID:

## Typical Developmentally Appropriate Health Education Topics

**9 and 10 Year Old Visit**

- Discuss puberty and physical changes/sexuality
- Encourage constructive conflict resolution, demonstrate anger management at home
- Establish consistent limits/rules and consistent consequences
- Establish personal hygiene routine
- Increase difficulty of chores to develop sense of accomplishment and increase self-confidence
- Limit TV/computer time to 2 hours/day
- Provide nutritious meals and snacks; limit sweets/sodas/high-fat foods
- Establish tooth brushing routine twice a day
- During sports wear protective gear at all times
- Encourage outdoor play for 1 hour/day
- Develop a family plan for exiting house in a fire/establish meeting place after exit
- Discuss drug/tobacco/alcohol use and peer pressure
- Get to know child's friends and their parents
- Lock up guns
- Promote use of seat belt and ride in back seat until 12 years old
- 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 self-safety if feeling unsafe at friend's home/car, answer the door/telephone when adult not home, personal body privacy
- Discuss additional help with teacher if there are concerns/bullying
- Discuss school activities and school work
- Provide space/time for homework/personal time

**See Bright Futures for assistance*

| TB QUESTIONNAIRE **Place a mark in the appropriate box:** | Yes | Do not know | No |
|---|---|---|---|
| Has your child been tested for TB? | ☐ | ☐ | ☐ |
| If yes, specify date | | | |
| Has your child ever had a positive TB skin test? | ☐ | ☐ | ☐ |
| If yes, specify date | | | |
| TB can cause fever of long duration, 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? or | ☐ | ☐ | ☐ |
| has your child had any of these symptoms or problems? or | ☐ | ☐ | ☐ |
| has your child been around anyone sick with TB? | ☐ | ☐ | ☐ |
| 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? | ☐ | ☐ | ☐ |