

NAME: \_\_\_\_\_  
 DOB: \_\_\_\_\_  
 GENDER:  MALE  FEMALE  
 DATE OF SERVICE: \_\_\_\_\_

MEDICAID ID: \_\_\_\_\_  
 PRIMARY CARE GIVER: \_\_\_\_\_  
 PHONE: \_\_\_\_\_  
 INFORMANT: \_\_\_\_\_

**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  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: \_\_\_\_\_

**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):

<input type="checkbox"/> Appearance	<input type="checkbox"/> Mouth/throat	<input type="checkbox"/> Genitalia
<input type="checkbox"/> Head/fontanelles	<input type="checkbox"/> Teeth	<input type="checkbox"/> Extremities
<input type="checkbox"/> Skin	<input type="checkbox"/> Neck	<input type="checkbox"/> Back
<input type="checkbox"/> Eyes	<input type="checkbox"/> Heart/pulses	<input type="checkbox"/> Musculoskeletal
<input type="checkbox"/> Ears	<input type="checkbox"/> Lungs	<input type="checkbox"/> Hips
<input type="checkbox"/> Nose	<input type="checkbox"/> Abdomen	<input type="checkbox"/> 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 \_\_\_\_\_

Signature/title \_\_\_\_\_

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)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has your child ever had a positive TB skin test? If yes, when (date)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
has your child been around anyone sick with TB?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
has your child had any of these symptoms or problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was your child born in Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe, or Asia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

#### HEARING CHECKLIST FOR PARENTS (OPTIONAL)

	Yes	No	
<b>Ages 9 to 12 months</b>	<input type="checkbox"/>	<input type="checkbox"/>	Points to or looks at familiar objects or people when asked to
	<input type="checkbox"/>	<input type="checkbox"/>	Looks sad when scolded
	<input type="checkbox"/>	<input type="checkbox"/>	Follows directions ("Open your mouth," "Give me the ball")
	<input type="checkbox"/>	<input type="checkbox"/>	Dances and makes sounds to music
	<input type="checkbox"/>	<input type="checkbox"/>	Uses jargon (appears to be talking)
	<input type="checkbox"/>	<input type="checkbox"/>	Uses consonant sounds like b, d, g, m, and n when talking
	<input type="checkbox"/>	<input type="checkbox"/>	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>