

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 SCREENING:

Use of standardized tool: P ☐ F ☐

☐ ASQ ☐ PEDS

Autism screening: P ☐ F ☐

☐ M-CHAT

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-Hep B
☐ DTaP-IPV/Hib ☐ Influenza

*Special populations: See ACIP

LABORATORY

Tests ordered today:

☐ Hgb/Hct

☐ Blood lead test

Other: _____

UNCLOTHED PHYSICAL EXAM

☐ See growth graph

Weight: _____ (_____ %) Length: _____ (_____ %)

BMI: _____ (_____ %) 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*:

- Communication
- Development/Behaviors
- Social Interaction
- Discipline
- Nutrition
- Safety

*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

24 Month Checkup

- Assist in use of language to express feelings
- Encourage supervised outdoor exercise
- Establish consistent bedtime routine
- Establish consistent limits/rules and consistent consequences
- Establish routine and assist with tooth brushing with soft brush twice a day
- Limit TV time to 1-2 hours/day
- Maintain consistent family routine
- Progress with toilet training by providing frequent "potty" breaks every 2 hours
- Provide age-appropriate toys to develop imagination/self-expression
- Read books and talk about pictures/story using simple words
- Be aware of language used, child will imitate
- Teach hand-washing
- Discipline constructively using time-out for 1 minute/year of age
- Praise good behavior
- Provide nutritious 3 meals and 2 snacks; limit sweets/high-fat foods
- Lock up guns
- No shaking baby (Shaken Baby Syndrome)
- Provide home safety for fire/carbon monoxide poisoning
- Provide safe/quality day care, if needed
- Supervise within arm's length when near or in water
- Use of front-facing car seat until 4 years old and 40 pounds
- Provide opportunities for side-by-side play with others of same age group
- Use of "No" for self-opinion/frustration/expression of anger

TB QUESTIONNAIRE Place a mark in the appropriate box:

	Yes	Do not know	No
Has your child been tested for TB?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, when (date)			
Has your child ever had a positive TB skin test?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HEARING CHECKLIST FOR PARENTS (OPTIONAL)

	Yes	No	
Ages 18 to 24 months	<input type="checkbox"/>	<input type="checkbox"/>	Understands simple "yes/no" questions
	<input type="checkbox"/>	<input type="checkbox"/>	Understands simple phrases with prepositions ("in the cup")
	<input type="checkbox"/>	<input type="checkbox"/>	Enjoys being read to and points to pictures when asked
	<input type="checkbox"/>	<input type="checkbox"/>	Uses his or her own first name
	<input type="checkbox"/>	<input type="checkbox"/>	Uses "my" to get toys and other objects
	<input type="checkbox"/>	<input type="checkbox"/>	Tells experiences using jargon and words
	<input type="checkbox"/>	<input type="checkbox"/>	Uses 2-word sentences like "my shoes," "go bye-bye," "more juice"

EARLY CHILDHOOD INTERVENTION (ECI)

The ECI referral form is available at:

<http://txpeds.org/sites/txpeds.org/files/documents/ECI-Referral-Form.pdf>