

NAME:
DOB:
GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> 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:

**DEVELOPMENTAL SURVEILLANCE:**

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

**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  
 MMR  Pneumococcal\*  Meningococcal\*  
 Varicella  MMRV  DTaP-IPV-Hep B  
 DTaP-IPV/Hib  Influenza  
*\*Special populations: See ACIP*

### LABORATORY

Tests ordered today:

### UNCLOTHED PHYSICAL EXAM

See growth graph

Weight: \_\_\_\_\_ ( \_\_\_\_\_ %) Length: \_\_\_\_\_ ( \_\_\_\_\_ %)

BMI: \_\_\_\_\_ ( \_\_\_\_\_ %) 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/fontanel | <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       | • Nutrition |
| • Social Interactions | • Safety    |
| • Development         |             |

*\*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

#### 30 Month Checkup

- Lead risk assessment\*
- Read books and talk about pictures/story using simple words
- Remain aware of language used, child will imitate
- Begin self-dressing with T-shirt
- Discipline constructively using time out for 1 minute/year of age
- 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/computer time to 1-2 hours/day
- Maintain consistent family routine
- Provide age-appropriate toys to develop imagination/self-expression
- 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 when near or in water even if child knows how to swim
- Teach how to answer the telephone
- Use of front-facing car seat until 4 y/o and 40 pounds
- Encourage supervised outdoor exercise
- Use of "No" for self-opinion/frustration/expression of anger

### HEARING CHECKLIST FOR PARENTS (OPTIONAL)

	Yes	No	
	<input type="checkbox"/>	<input type="checkbox"/>	Understands negative statements ("no more," "not now")
	<input type="checkbox"/>	<input type="checkbox"/>	Selects objects according to size (big, little)
<b>24 to 30 months</b>	<input type="checkbox"/>	<input type="checkbox"/>	Follows simple directions ("Get your shoes and socks")
	<input type="checkbox"/>	<input type="checkbox"/>	Answers questions ("What do you do when you are sleepy?")
	<input type="checkbox"/>	<input type="checkbox"/>	Uses plural words (2 books, dogs)
	<input type="checkbox"/>	<input type="checkbox"/>	Speaks 100 to 200 words

### \*LEAD RISK FACTORS

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

The use of the Form Pb-110, Lead Risk Questionnaire is optional. It is available at [www.dshs.state.tx.us/thsteps/forms.shtm](http://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.

### EARLY CHILDHOOD INTERVENTION (ECI)

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