

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:

TB questionnaire\*, risk identified: Y  N

\*TB skin test if indicated  TST  
(See back for form)

**DEVELOPMENTAL SURVEILLANCE:**

- 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  
 Meningococcal\*  MMR  Pneumococcal\*  
 Varicella  MMRV  DTaP-IPV  
 DTaP-IPV-Hep B  Influenza

\*Special populations: See ACIP

**LABORATORY**

Tests ordered today:

**UNCLOTHED PHYSICAL EXAM**

See growth graph

Weight: \_\_\_\_\_ ( \_\_\_\_\_ %) Height: \_\_\_\_\_ ( \_\_\_\_\_ %)

BMI: \_\_\_\_\_ ( \_\_\_\_\_ %) Heart Rate: \_\_\_\_\_

Blood Pressure: \_\_\_\_\_ / \_\_\_\_\_ 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"/> Nose         | <input type="checkbox"/> Lungs           |
| <input type="checkbox"/> Head       | <input type="checkbox"/> Mouth/throat | <input type="checkbox"/> GI/abdomen      |
| <input type="checkbox"/> Skin       | <input type="checkbox"/> Teeth        | <input type="checkbox"/> Extremities     |
| <input type="checkbox"/> Eyes       | <input type="checkbox"/> Neck         | <input type="checkbox"/> Back            |
| <input type="checkbox"/> Ears       | <input type="checkbox"/> Heart        | <input type="checkbox"/> Musculoskeletal |
|                                     |                                       | <input type="checkbox"/> Neurological    |

Abnormal findings:

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 Activities
- Nutrition
- Development
- Safety
- Physical Activities

\*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

#### 5 Year Old Checkup

- Lead risk assessment\*
- Encourage child to tell the story his/her way
- Encourage constructive conflict resolution, demonstrate at home
- Establish consistent bedtime routine
- Establish consistent limits/rules and consistent consequences
- Establish daily chores to develop sense of accomplishment and increase self-confidence
- 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
- Read and discuss story daily
- Show affection/praise for good behaviors
- Provide nutritious 3 meals and 2 snacks; limit sweets/sodas/high-fat foods
- During sports wear protective gear at all times
- Encourage supervised outdoor play for 1 hour/day
- Develop a family plan for exiting house in a fire/establish meeting place after exit
- Lock up guns
- 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 how to answer the door/telephone
- Teach self-safety for personal privacy
- Teach street safety/running after balls/crossing street/riding bicycle/boarding bus
- Use of booster seat in back seat of car until 4ft 9in or 8 years old
- Advocate with teacher for child with school difficulties/bullying
- Discuss school activities 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"/>

#### \*LEAD RISK FACTORS

Perform a blood lead test if parent/caretaker answers "Yes/Don't Know" to any of the questions below.

	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.