

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, including

Maternal Depression: 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*:

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 B Hib IPV

PCV Hib-Hep B Rotavirus

DTaP-IPV-Hep B DTaP-IPV/Hib Influenza

LABORATORY

Tests ordered today:

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):

Appearance	Mouth/throat	Genitalia
Head/fontanel	Teeth	Extremities
Skin	Neck	Back
Eyes	Heart/pulses	Musculoskeletal
Ears	Lungs	Hips
Nose	Abdomen	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 Interaction
- Establishing a Dental Home
- Safety
- Infant Development/Behavior
- Nutrition and Feeding

**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

6 Month Checkup

- Lead risk assessment*
- Maintain consistent family routine
- Do not use walker
- Promote language using simple words
- Provide age-appropriate toys, remove small toys/pins/plastic pieces
- Read books and talk about pictures/story using simple words
- Use distraction for discipline
- Introduce solids slowly, one at a time
- No bottle in bed
- Store breastmilk in freezer
- Store prepared formula (for daily use only) in refrigerator
- Clean mouth/teeth with soft cloth twice a day
- Crib safety with slats $\leq 2\text{-}3/8$ "
- Do not leave alone in bath water
- Home safety for fire/carbon monoxide poisoning, stair/window gates, electrical outlet covers, cleaning supplies, and medicines out of reach
- Keep hand on infant when on bed or changing on table/couch
- Lock up guns
- Mash up table foods if given, no hot dogs cut into circles
- No shaking baby (Shaken Baby Syndrome)
- Provide safe/quality day care, if needed
- Sleep in crib on back with no loose covers
- Use rear-facing car seat in back seat of car until 12 months and 20 pounds

HEARING CHECKLIST FOR PARENTS (OPTIONAL)

		Yes	No
Ages 3 to 6 months			Looks to see where sounds come from
			Becomes frightened by an angry voice
			Smiles when spoken to
			Likes to play with toys or objects that make noise
			Babbles (uses a series of sounds)
		Makes at least 4 different sounds when using his or her voice	
		Babbles to people when they speak	

*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. 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>