

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
*Tuberculin Skin Test if indicated TST
(TB questionnaire-Page 2)

DEVELOPMENTAL/MENTAL HEALTH SCREENING:

Use of standardized tool: ASQ PEDS P F
Autism screening: M-CHAT™ M-CHAT-R/F™ P F
Findings:

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:
 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):

Appearance	Mouth/throat	Genitalia
Head/fontanel	Teeth	Extremities
Skin	Neck	Back
Eyes	Heart/pulses	Musculoskeletal
Ears	Lungs	Hips
Nose	Abdomen	Neurological

Abnormal findings:

SENSORY SCREENING:

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?
If yes, when (date) _____

Has your child ever had a positive Tuberculin Skin Test?
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?
has your child been around anyone sick with TB?
has your child had any of these symptoms or problems?

Was your child born in Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe, or Asia?

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? _____

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?

HEARING CHECKLIST FOR PARENTS (OPTIONAL)

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

EARLY CHILDHOOD INTERVENTION (ECI)

The ECI Physician Referral and Orders for Early Childhood Intervention (ECI) form is available at:
<https://hhs.texas.gov/services/disability/early-childhood-intervention-services/eci-information-health-medical-professionals>