

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:

**DEVELOPMENTAL SURVEILLANCE:**

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

Autism screening (If not completed at 24 mos):  
 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  
                   MMR    Pneumococcal\*    Meningococcal\*  
                   Varicella    MMRV    DTaP-IPV-Hep B  
                   DTaP-IPV/Hib    Influenza

*\*Special populations: See ACIP*

**LABORATORY**

Tests ordered today:

\_\_\_\_\_  
 Signature/title

**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):

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
- Social Interactions
- Development
- 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

#### 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
<b>24 to 30 months</b>		<ul style="list-style-type: none"> <li>Understands negative statements ("no more," "not now")</li> <li>Selects objects according to size (big, little)</li> <li>Follows simple directions ("Get your shoes and socks")</li> <li>Answers questions ("What do you do when you are sleepy?")</li> <li>Uses plural words (2 books, dogs)</li> <li>Speaks 100 to 200 words</li> </ul>

#### \*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			
• Pica (eats non-food items)			
• Family member with an elevated blood lead level			
• Child is a newly arrived refugee or foreign adoptee			
• Exposure to an adult with hobbies or jobs that may have risk of lead contamination (See Pb-110 for a list)			
• Food sources (including candy) or remedies (see Pb-110 for a list)			
• Imported or glazed pottery			
• Cosmetics that may contain lead (see Pb-110 for a list)			

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

### 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>