

NAME:
DOB:
GENDER:
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:

Lead questionnaire, risk identified: Y  N   
(See back for form)

**DEVELOPMENT:**

Use of standardized tool: P  F

ASQ\*  PEDS\*  Other

Autism screening: P  F

MCHAT\*  Other

\*ASQ, PEDS, M-CHAT required for use as of 9/1/11

**NUTRITION\*:**

Breast  Bottle  Cup

Milk (%): \_\_\_\_\_ Ounces per day: \_\_\_\_\_

Solid foods: \_\_\_\_\_

Juice: \_\_\_\_\_

Water source: \_\_\_\_\_ fluoride: Y  N

\*See Bright Futures Nutrition Book if needed

**IMMUNIZATIONS**

Up-to-date  
 Deferred - Reason:

Given today:  DTaP  HAV  HBV  HIB  IPV

MMR  Pneumococcal  Varicella  MMR-V

HIB-HBV  DTap-HIB  DTaP-HB-IPV

DTaP-IPV-HIB  Influenza

**LABORATORY**

Up-to-date  
 Deferred - Reason:

Ordered today:

**UNCLOTHED PHYSICAL EXAM**

See growth graph

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

Head Circumference: \_\_\_\_\_ ( \_\_\_\_\_ %)

Heart Rate: \_\_\_\_\_ Respiratory Rate: \_\_\_\_\_

Temperature: \_\_\_\_\_

Normal (Mark here if all items are WNL)

Abnormal (Mark all that apply and describe):

Appearance  Nose  Abdomen

Head/fontanelles  Mouth/throat  Genitalia

Skin  Teeth  Extremities

Eyes  Neurological  Back

Ears  Heart/pulses  Musculoskeletal

Lungs  Hips

Abnormal findings:

Additional:

Teeth # \_\_\_\_\_

Subjective Vision Screening: P  F

Hearing Checklist for Parents: P  F

(See back for form)

**HEALTH EDUCATION/ANTICIPATORY GUIDANCE (See back for useful topics)**

Selected health topics addressed in any of the following areas\*:

- Family Support
- Development/Behaviors
- Communication
- Nutrition
- Safety

**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**

**18 Month Visit**

- Assist to describe feelings in simple words
- Provide age-appropriate toys to develop imagination/self-expression
- Read books and talk about pictures/story using simple words
- Begin toilet training when ready
- Discipline constructively using time-out for 1 minute/year of age
- Encourage supervised outdoor play
- 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

- Praise good behavior
- Provide opportunities for side-by-side play with others of same age group
- Maintain consistent family routine
- Make 1:1 time for each child in family
- Be aware of language used, child will imitate
- Provide nutritious 3 meals and 2 snacks; limit sweets/high-fat foods
- Home safety for fire/carbon monoxide poisoning, stair/window gates, electrical outlet covers
- Lock up guns
- No shaking baby (Shaken Baby Syndrome)
- Provide safe/quality day care
- Supervise within arm's length when near water
- Use of front-facing car seat in back seat of car if >20 pounds

*\*See Bright Futures for assistance*

**HEARING CHECKLIST FOR PARENTS**

	Yes	No	
<b>Ages 16 to 24 months</b>	<input type="checkbox"/>	<input type="checkbox"/>	Does your child use his/her voice most of the time to get what he/she wants or to communicate with you?
	<input type="checkbox"/>	<input type="checkbox"/>	Can your child go get familiar objects that are kept in a regular place if you ask him/her ("Get your shoes.")?

**If you answered "no" to any of the above questions, ask your doctor about a hearing test for your baby. Babies can be tested as soon as the day of birth.**

**Risk Assessment for Lead Exposure: Parent Questionnaire**

	Yes	Do not know	No
<b>1</b> Does your child live in or visit a home, day care, or other building built before 1978?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>2</b> Does your child live in or visit a home, day care, or other building with ongoing repairs or remodeling?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>3</b> Does your child eat or chew on non-food things like paint chips or dirt?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>4</b> Does your child have a family member or friend who has or did have an elevated blood lead level?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>5</b> Is your child a newly arrived refugee or foreign adoptee?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>6</b> Is your child exposed to any of the following (if YES, check all that apply): Contamination from a parent, relative, or friend with jobs or hobbies like these?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Radiator repair	<input type="checkbox"/> House construction or repair	<input type="checkbox"/> Chemical preparation	<i>If "Yes" or "Do not know" perform a Blood Lead Test</i>
<input type="checkbox"/> Pottery making	<input type="checkbox"/> Battery manufacture or repair	<input type="checkbox"/> Valve and pipe fittings	
<input type="checkbox"/> Lead smelting	<input type="checkbox"/> Burning lead-painted wood	<input type="checkbox"/> Brass/copper foundry	
<input type="checkbox"/> Welding	<input type="checkbox"/> Automotive repair shop or junkyard	<input type="checkbox"/> Refinishing furniture	
<input type="checkbox"/> Making fishing weights	<input type="checkbox"/> Going to a firing range or reloading bullets	<input type="checkbox"/> Other:	

Sources of lead in food and remedies?

- Imported or glazed pottery such as a Mexican bean pot
- Imported candy, (like Chaca Chaca) especially from Mexico
- Nutritional pills other than vitamins
- Other:
- Foods canned or packaged outside the U.S.
- Remedies such as greta, azarcón, alarcón, alkohl, bali goli, coral, ghasard, liga, pay-loo-ah, rueda

Fax completed form to 512-458-7699, or mail to the address below.  
Texas Childhood Lead Poisoning Prevention Program • PO BOX 149347 • Austin, TX 78714-9347 • 1-800-588-1248 • www.dshs.state.tx.us/lead