

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

*ASQ, PEDS, required for use as of 9/1/11

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 HBV HIB IPV

Pneumococcal HIB-HBV DTap-HIB

Rotavirus 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 Functioning
- Nutrition/Feeding Routine
- Safety
- Infant Development/Behavior

ASSESSMENT

PLAN/REFERRALS

Referral(s):

Return to office:

Signature/title

Signature/title

Name:

Medicaid ID:

Typical Developmentally Appropriate Health Education Topics

9 Month Visit

- Establish consistent bedtime routine
- Maintain consistent family routine
- Make 1:1 time for each child in family
- Establish routine and assist with tooth brushing with soft brush twice a day
- Limit TV time to 1-2 hours/day
- Praise good behavior
- Promote language using simple words
- Provide age-appropriate toys
- Provide favorite toy for self-soothing during sleep time
- Provide nap time daily
- Read books and talk about pictures/story using simple words
- Separation anxiety common
- Use distraction or choice of 2 appropriate options for discipline
- Introduce cup and encourage use to begin weaning process
- No bottle in bed
- Slowly increase choice of solids
- Cut table foods small, no hot dogs cut into circles
- Do not leave alone in bath water
- Empty all buckets containing water
- Home safety for fire/carbon monoxide poisoning, stair/window gates, electrical outlet covers, cleaning supplies, and medicines out of reach, remove all buckets
- Lock up guns
- No shaking baby (Shaken Baby Syndrome)
- Provide safe/quality day care, if needed
- Remove small toys/pins/plastic pieces to allow safe exploration
- Use rear-facing car seat in back seat of car until 12 months and 20 pounds

**See Bright Futures for assistance*

HEARING CHECKLIST FOR PARENTS

	Yes	No	
Ages 7 to 9 months	<input type="checkbox"/>	<input type="checkbox"/>	Does your baby stop and pay attention when you say “no” or call his/her name?
	<input type="checkbox"/>	<input type="checkbox"/>	Does your baby move his/her head around to try and find out where a new sound is coming from?
	<input type="checkbox"/>	<input type="checkbox"/>	Does your baby make strings of sounds (“ba ba ba, da da da”)?

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
1 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"/>
2 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"/>
3 Does your child eat or chew on non-food things like paint chips or dirt?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 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"/>
5 Is your child a newly arrived refugee or foreign adoptee?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 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