NAME:	MEDICAID ID:
DOB:	PRIMARY CARE GIVER:
GENDER: MALE FEMALE	PHONE:
DATE OF SERVICE:	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 ☐
☐ TB questionnaire*, risk identified: Y ☐ N ☐
**Tuberculin skin test if indicated* ☐ TST
(See back for forms)

DEVELOPMENT SCREENING:
Use of standardized tool:
ASQ ☐ ASQ:SE ☐ PEDS ☐ P☐ F☐

NUTRITION*:
Problems: Y ☐ N☐
Assessment:

**See Bright Futures Nutrition Book if needed*

IMMUNIZATIONS

☐ Up-to-date
☐ Deferred - Reason:

Given today: ☐ DTaP ☐ HAV ☐ HBV ☐ HIB ☐ IPV
☐ Meningococcal ☐ MMR ☐ Pneumococcal
☐ Varicella ☐ MMR-V ☐ HIB-HBV ☐ DTap-HIB
☐ DTaP-HB-IPV ☐ DTaP-IPV-HIB ☐ Influenza

LABORATORY

Up-to-date
Deferred - Reason:

Ordered today:

Signature/title

UNCLOTHED PHYSICAL EXAM

☐ See growth graph

Weight: _______ (______%) Height: _______ (______%)
BMI: _______ (______%) Heart Rate: ______________
Blood Pressure: _____/_____ Respiratory Rate: __________
Temperature: _____________

☐ Normal (Mark here if all items are WNL)

Abnormal (Mark all that apply and describe):

☐ Appearance	☐ Nose	☐ Lungs
☐ Head	☐ Mouth/throat	☐ Abdomen
☐ Skin	☐ Teeth	☐ Genitalia
☐ Eyes	☐ Neurological	☐ Extremities
☐ Ears	☐ Heart	☐ Back
		☐ Musculoskeletal

Abnormal findings:

Visual Acuity Screening:
OD____/_____ OS____/_____ OU____/_____

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*:
- School Readiness
- Nutrition
- Development
- Safety
- Physical Activity

ASSESSMENT

PLAN/REFERRALS

Dental Referral: Y ☐
Other Referral(s)

Return to office: ______________________

Signature/title

Texas Health Steps

3 YEAR VISIT CHILD HEALTH RECORD