

NAME:
DOB:
GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> 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 (See back for form)* TST

DEVELOPMENTAL SURVEILLANCE:

- Communication skills/language development
- Self-help/care skills
- Social, emotional development
- Cognitive development
- Mental health

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
 DTaP-IPV-Hep B Influenza

*Special populations: See ACIP

LABORATORY

Tests ordered today:

UNCLOTHED PHYSICAL EXAM

See growth graph

Weight: _____ (_____ %) Height: _____ (_____ %)

BMI: _____ (_____ %) Heart Rate: _____

Blood Pressure: _____ / _____ Respiratory Rate: _____

Temperature (optional): _____

Normal (Mark here if all items are WNL)

Abnormal (Mark all that apply and describe):

- | | | |
|-------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Appearance | <input type="checkbox"/> Nose | <input type="checkbox"/> Lungs |
| <input type="checkbox"/> Head | <input type="checkbox"/> Mouth/throat | <input type="checkbox"/> GI/abdomen |
| <input type="checkbox"/> Skin | <input type="checkbox"/> Teeth | <input type="checkbox"/> Extremities |
| <input type="checkbox"/> Eyes | <input type="checkbox"/> Neck | <input type="checkbox"/> Back |
| <input type="checkbox"/> Ears | <input type="checkbox"/> Heart | <input type="checkbox"/> Musculoskeletal |
| | | <input type="checkbox"/> Neurological |

Abnormal findings:

Audiometric Screening:

R 1000Hz _____ 2000HZ _____ 4000HZ _____

L 1000Hz _____ 2000HZ _____ 4000HZ _____

Visual Acuity Screening:

OD _____ / _____ OS _____ / _____ OU _____ / _____

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

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

- School Activities
- Nutrition
- Development
- Safety
- Physical Activities

*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

5 Year Old Checkup

- Lead risk assessment*
- Encourage child to tell the story his/her way
- Encourage constructive conflict resolution, demonstrate at home
- Establish consistent bedtime routine
- Establish consistent limits/rules and consistent consequences
- Establish daily chores to develop sense of accomplishment and increase self-confidence
- 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
- Read and discuss story daily
- Show affection/praise for good behaviors
- Provide nutritious 3 meals and 2 snacks; limit sweets/sodas/high-fat foods
- During sports wear protective gear at all times
- Encourage supervised outdoor play for 1 hour/day
- Develop a family plan for exiting house in a fire/establish meeting place after exit
- Lock up guns
- Provide home safety for fire/carbon monoxide poisoning
- Provide safe/quality after-school care
- Supervise when near or in water even if child knows how to swim
- Teach how to answer the door/telephone
- Teach self-safety for personal privacy
- Teach street safety/running after balls/crossing street/riding bicycle/boarding bus
- Use of booster seat in back seat of car until 4ft 9in or 8 years old
- Advocate with teacher for child with school difficulties/bullying
- Discuss school activities daily

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)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has your child ever had a positive Tuberculin Skin Test? If yes, when (date)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
has your child been around anyone sick with TB?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
has your child had any of these symptoms or problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was your child born in Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe, or Asia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

The use of the Form Pb-110, Lead Risk Questionnaire is optional. It is available at www.dshs.texas.gov/thsteps/forms.shtm. If completed, return the form to the Texas Childhood Lead Poisoning Prevention Program as directed on the form.