12 MONTH CHECKUP — CHILD HEALTH RECORD

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, including Post-partum Depression Screening (use of validated tool required): EPDS PPDS PHQ-9 Other P F

Findings:

TB questionnaire*, risk identified: Y N

**Tuberculin Skin Test if indicated* (TB questionnaire, p. 2) TST

DEVELOPMENTAL SURVEILLANCE:

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

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 (if deferred):

Given today: DTaP Hep A Hep B Hib IPV
MMR PCV Meningococcal* Varicella
MMRV Hib-Hep B DTaP-IPV-Hep B
DTaP-IPV/Hib Influenza

**Special populations: See ACIP*

LABORATORY

Tests ordered today:

Hgb/Hct: Y N

Blood lead test: Y N

Other:

Signature/title

UNCLOTHED PHYSICAL EXAM

See growth graph

Weight: _______ (_______%) Length: _______ (_______%)

Head Circumference: _______ (_______%)

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/fontanels	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*:

- Family Interactions
- Nutrition
- Setting Routines
- Safety
- Development/Behaviors

**See Bright Futures for assistance*

ASSESSMENT

PLAN/REFERRALS

Dental Referral: Y

Other Referral(s)

Return to office:

Signature/title

Name: | Medicaid ID:

Typical Developmentally Appropriate Health Education Topics

12 Month Checkup

- Begin weaning from bottle/breast to cup
- Discipline constructively using time-out for 1 minute/ year of age
- Encourage supervised outdoor play
- Establish consistent limits/rules and consistent consequences
- 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
- Read books and talk about pictures/story using simple words
- Use distraction or choice of 2 appropriate options to avoid/resolve conflicts
- Make 1:1 time for each child in family
- No bottle in bed
- Provide nutritious 3 meals and 2 snacks; limit sweets/ high-fat foods
- 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
- Lock up guns
- Provide safe/quality day care, if needed
- Supervise within arm's length when near water/do not leave alone in bath water
- Use of front-facing car seat in back seat of car if >20 pounds
- Establish consistent bedtime routine
- Establish routine and assist with tooth brushing with soft brush twice a day
- Maintain consistent family routine
- Provide nap time 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)			
Has your child ever had a positive Tuberculin Skin Test? If yes, when (date)			
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?			
has your child been around anyone sick with TB?			
has your child had any of these symptoms or problems?			
Was your child born in Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe, or Asia?			
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?			
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?			

HEARING CHECKLIST FOR PARENTS (OPTIONAL)

	Yes	No	
Ages 9 to 12 months			Points to or looks at familiar objects or people when asked to
			Looks sad when scolded
			Follows directions ("Open your mouth," "Give me the ball")
			Dances and makes sounds to music
			Uses jargon (appears to be talking)
			Uses consonant sounds like b, d, g, m, and n when talking
			Jabbers in response to a human voice, changes loudness of voice, and uses rhythm and tone

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