

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

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 B	Hib
	IPV	Hib-Hep B	
	PCV		
	DTaP-IPV-Hep B		DTaP-IPV/Hib
	Rotavirus		

LABORATORY

Tests ordered today:

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	Extremities
Head/fontanel	Neck	Back
Skin	Heart/pulses	Musculoskeletal
Eyes	Lungs	Hips
Ears	Abdomen	Neurological
Nose	Genitalia	

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 Interaction
- Oral Health
- Infant Development/Behavior
- Safety
- Nutrition

**See Bright Futures for assistance*

ASSESSMENT

PLAN/REFERRALS

Referral(s):

Return to office:

Signature/title

Signature/title

Name: Medicaid ID:

Typical Developmentally Appropriate Health Education Topics

4 Month Checkup

- Maintain consistent family routine
- Promote language using simple words
- Provide age-appropriate toys, remove small toys/pins/plastic pieces
- Read books and talk about pictures/story using simple words
- Hold to bottle-feed, no bottle propping
- Introduce cereal when ready
- No bottle in bed
- No microwave to heat milk
- Store breastmilk in freezer
- Store prepared formula (for daily use only) in refrigerator
- Clean mouth/teeth with soft cloth twice a day
- Crib safety with slats $\leq 2\text{-}3/8"$
- Do not leave alone in bath water
- Home safety for fire/carbon monoxide poisoning
- Keep hand on infant when on bed or changing on table/couch
- No shaking baby (Shaken Baby Syndrome)
- Provide safe/quality day care, if needed
- Sleep in crib on back with no loose covers
- Use rear-facing car seat in back seat of car until 12 months and 20 pounds
- Water heater at $<120^\circ$

HEARING CHECKLIST FOR PARENTS (OPTIONAL)

	Yes	No
Ages		
3 to 6 months		<ul style="list-style-type: none"> Looks to see where sounds come from Becomes frightened by an angry voice Smiles when spoken to Likes to play with toys or objects that make noise Babbles (uses a series of sounds) Makes at least 4 different sounds when using his or her voice Babbles to people when they speak

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>