| | |
|---|---|
| NAME: | MEDICAID ID: |
| DOB: | PRIMARY CARE GIVER: |
| GENDER: ☐ MALE ☐ FEMALE | PHONE: |
| DATE OF SERVICE: | INFORMANT: |

Texas Health Steps

# 6 MONTH CHECKUP CHILD HEALTH RECORD

## 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
Maternal Depression: Y ○ N ○
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:

Given today: ☐ DTaP ☐ Hep B ☐ Hib ☐ IPV
☐ PCV ☐ Hib-Hep B ☐ Rotavirus
☐ DTaP-IPV-Hep B ☐ DTaP-IPV/Hib ☐ Influenza

## LABORATORY

Tests ordered today:

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:

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
- Establishing a Dental Home
- Safety
- Infant Development/Behavior
- Nutrition and Feeding

**See Bright Futures for assistance*

## ASSESSMENT

## PLAN/REFERRALS

Dental Referral: Y ☐
Other Referral(s)

Return to office: _____

Signature/title

Texas Health Steps

CHILD HEALTH RECORD

6 MONTH CHECKUP

Name: | Medicaid ID:

## Typical Developmentally Appropriate Health Education Topics

**6 Month Checkup**

- Lead risk assessment*
- Maintain consistent family routine
- Do not use walker
- 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
- Use distraction for discipline
- Introduce solids slowly, one at a time
- No bottle in bed
- 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 ≤2-3/8”
- Do not leave alone in bath water
- Home safety for fire/carbon monoxide poisoning, stair/window gates, electrical outlet covers, cleaning supplies, and medicines out of reach
- Keep hand on infant when on bed or changing on table/couch
- Lock up guns
- Mash up table foods if given, no hot dogs cut into circles
- 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

## HEARING CHECKLIST FOR PARENTS (OPTIONAL)

| | Yes | No | |
|---|---|---|---|
| **Ages 3 to 6 months** | ○ | ○ | 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 |

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

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.

## EARLY CHILDHOOD INTERVENTION (ECI)

**The ECI referral form is available at:**
http://txpeds.org/sites/txpeds.org/files/documents/ECI-Referral-Form.pdf