

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: Y N
Findings:

DEVELOPMENTAL SCREENING:

Use of standardized tool: ASQ PEDS P F

Autism screening: M-CHAT™ M-CHAT-R/F™ P F

Findings:

NUTRITION*:

Breast Bottle Cup
Milk (%): _____ Ounces per day: _____
Solid foods: _____
Juice: _____
Water source: _____ fluoride: Y N

**See Bright Futures Nutrition Book if needed*

IMMUNIZATIONS

Up-to-date
Deferred - Reason:

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

**Special populations: See ACIP*

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	Genitalia
Head/fontanel	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 Support
- Development/Behaviors
- Communication
- Nutrition
- Safety

**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

18 Month Checkup

- Lead risk assessment*
- Assist to describe feelings in simple words
- Provide age-appropriate toys to develop imagination/self-expression
- Read books and talk about pictures/story using simple words
- Begin toilet training when ready
- Discipline constructively using time-out for 1 minute/year of age
- Encourage supervised outdoor play
- Establish consistent bedtime routine
- Establish consistent limits/rules and consistent consequences
- Establish routine and assist with tooth brushing with soft brush twice a day
- Limit TV time to 1-2 hours/day
- Praise good behavior
- Provide opportunities for side-by-side play with others of same age group
- Maintain consistent family routine
- Make 1:1 time for each child in family
- Be aware of language used, child will imitate
- Provide nutritious 3 meals and 2 snacks; limit sweets/high-fat foods
- Home safety for fire/carbon monoxide poisoning, stair/window gates, electrical outlet covers
- Lock up guns
- No shaking baby (Shaken Baby Syndrome)
- Provide safe/quality day care, if needed
- Supervise within arm's length when near water
- Use of front-facing car seat in back seat of car if >20 pounds

HEARING CHECKLIST FOR PARENTS (OPTIONAL)

Ages 18 to 24 months	Yes	No
		Understands simple "yes/no" questions
		Understands simple phrases with prepositions ("in the cup")
		Enjoys being read to and points to pictures when asked
		Uses his or her own first name
		Uses "my" to get toys and other objects
		Tells experiences using jargon and words
		Uses 2-word sentences like "my shoes," "go bye-bye," "more juice"

*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.

EARLY CHILDHOOD INTERVENTION (ECI)

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