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

12 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 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* ☐TST
(TB questionnaire, p. 2)

☐ **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:

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

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