NAME:	MEDICAID ID:
DOB:	INFORMANT/RELATIONSHIP:
AGE: GENDER:	MEDICAL HOME:

IF CHILD OVER 5 YEARS: uncomplicated pregnancy, labor, delivery and nursery course: Y ☐ * N ☐
**If yes, proceed with "Family and Personal Medical History"12/*

IF < 5 YEARS OLD

PREGNANCY

G ☐ P ☐ AB ☐

Total number of living children: _____ Weight gain/loss: _____
Mother's age at birth: _____
Number of years between previous pregnancy and this child: ___
Trimester Prenatal Care Began: 1 ☐ 2 ☐ 3 ☐
Prenatal Care Provider: _____
Vitamins: Y ☐ N ☐ Iron: Y ☐ N ☐

MATERNAL COMPLICATIONS

- ☐ Vaginal bleeding
- ☐ Anemia
- ☐ Hypertension
- ☐ Rh negative
- ☐ Diabetes
- ☐ Premature labor
- ☐ Dental disease
- ☐ Flu-like illness or high temp.
- ☐ Kidney or bladder infection
- ☐ STIs
- ☐ Hepatitis (A, B, or C)
- ☐ Exposure to TB or had TB
- ☐ Exposure to lead/chemicals
- ☐ Injury/hospitalization/surgery

MATERNAL SUBSTANCE USE

- ☐ OTC meds: _____
- ☐ Prescription meds: _____
- ☐ Tobacco: _____
- ☐ Alcohol: _____
- ☐ Street drugs: _____
- ☐ Caffeine: _____

BIRTH/DELIVERY

Place of birth: _____
Birth attendant: _____
Hours of labor: _____

☐ Term ☐ Premature (weeks): _____
☐ More than two weeks overdue

Type of delivery:
☐ Vaginal ☐ C-Section ☐ Forceps ☐ Other/Explanation:

Complications:
☐ Breech ☐ Multiple birth ☐ Other:

NURSERY COURSE

Birth Weight: _____ Birth Length: _____ FOC: _____

- ☐ Difficulty with initial breathing
- ☐ Jaundice req. treatment
- ☐ Infection
- ☐ Transfusion
- ☐ Heart murmur
- ☐ Seizures

☐ NICU: _____ days. Age at discharge: _____

Newborn blood screening (date/location):
1: _____
2: _____
Newborn hearing test (in hospital): ☐ Normal ☐ Abnormal
Type of test: ☐ ABR ☐ OAE ☐ Unknown
Referral made: Y ☐ N ☐
Comments:

FAMILY MEDICAL HISTORY

Abbreviations for relatives listed below.

M-Mother	MGM-Maternal Grandmother	PGM-Paternal Grandmother
F-Father	MGF-Maternal Grandfather	PGF-Paternal Grandfather
S-Sibling	MA-Maternal Aunt	PA-Paternal Aunt
	MU-Maternal Uncle	PU-Paternal Uncle

- ☐ ___ Anemia/blood disorder
- ☐ ___ Heart disease before age 50
- ☐ ___ Cholesterol req. treatment
- ☐ ___ Hypertension/stroke
- ☐ ___ Asthma/allergy
- ☐ ___ Cancer
- ☐ ___ Diabetes
- ☐ ___ Epilepsy/seizures
- ☐ ___ Kidney problems
- ☐ ___ Muscle/bone disease
- ☐ ___ Genetic disease or major birth defects
- ☐ ___ Tuberculosis
- ☐ ___ Other/Explanation:
- ☐ ___ HIV + individual in household *(do not identify)*
- ☐ ___ Other immunosuppression
- ☐ ___ Dental decay
- ☐ ___ Alcohol/drug abuse
- ☐ ___ Tobacco use
- ☐ ___ Learning disorder
- ☐ ___ Mental retardation
- ☐ ___ Psychiatric disorder
- ☐ ___ Physical/sexual/emotional abuse
- ☐ ___ Domestic violence
- ☐ ___ Childhood hearing impairment

PERSONAL MEDICAL HISTORY

Immunizations current: Y ☐ N ☐ Record unavailable ☐
Dental care current: Y ☐ N ☐ Sealants: Y ☐ N ☐

- ☐ Trauma/injuries
- ☐ Hospitalizations
- ☐ Surgery
- ☐ Medications
- ☐ Anemia
- ☐ Early childhood caries
- ☐ STIs
- ☐ Hepatitis
- ☐ Strep throat
- ☐ Ear infections
- ☐ Bladder/kidney infections
- ☐ Pneumonia
- ☐ Physical/sexual/emotional abuse
- ☐ Muscle/bone disease
- ☐ Other/Explanation:
- ☐ Vision problems
- ☐ Hearing problems
- ☐ Seizures
- ☐ Environmental toxin exposure (lead, etc.)
- ☐ Allergies
- ☐ Cancer
- ☐ Asthma
- ☐ Eczema
- ☐ Substance use (alcohol, drug, tobacco)
- ☐ Developmental delays/learning disorder
- ☐ Immune suppression
- ☐ Psychiatric disorder

Date: _____

_____
Signature/title

_____
Signature/title

Texas Health Steps

BIRTH THROUGH 20 YEARS HEALTH HISTORY

Texas Health Steps

BIRTH THROUGH 20 YEARS HEALTH HISTORY

IF USED FOR DOCUMENTATION:	MEDICAID ID:
PATIENT'S NAME:	DATE:

PROGRESS NOTES

TEXAS Department of State Health Services