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

Texas Health Steps

CHILD HEALTH RECORD

2 WEEK CHECKUP

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 ○

**See Bright Futures Nutrition Book if needed*

IMMUNIZATIONS

○ Up-to-date
○ Deferred - Reason:

Given today: ☐ Hep B

LABORATORY

○ Newborn screening panel ordered today
○ Deferred - Reason:

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

Abnormal findings:

Additional:
Subjective Hearing Screening: P ○ F ○
Subjective Vision Screening: P ○ F ○
Newborn Hearing Screening:
○ ABR ○ OAE ○ Unknown
Completion date: ____/____/____ Results:

HEALTH EDUCATION/ANTICIPATORY GUIDANCE *(See back for useful topics)*

☐ Selected health topics addressed in any of the following areas*:
- Infant/Family Adjustment
- Parental/Maternal Well-Being
- Safety
- Nutrition/Feeding Routines

**See Bright Futures for assistance*

ASSESSMENT

PLAN/REFERRALS

Referral(s):

Return to office: _____

Signature/title

Texas Health Steps

CHILD HEALTH RECORD

2 WEEK CHECKUP

Name: | Medicaid ID:

Typical Developmentally Appropriate Health Education Topics

2 Week Checkup

- Clean mouth with soft cloth twice a day
- Maintain consistent family routine
- No bed sharing
- No bottle in bed
- Skin, circumcision, umbilical care
- Sleep in crib on back with no loose covers
- Stooling-color, frequency
- Talk to infant using simple words telling/reading stories
- 6-8 wet diapers a day
- Adequate weight gain
- Hold to bottle-feed, no bottle propping
- No microwave to heat milk
- Store breast milk in freezer
- Store prepared formula (for daily use only) in refrigerator
- Postpartum checkup
- Postpartum depression/family stress
- Crib safety with slats ≤2-3/8”
- 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)
- Second-hand smoke
- Provide safe/quality day care, if needed
- Report domestic violence
- Return to work/school
- Thermometer use
- Use rear-facing car seat in back seat of car until 12 months and 20 pounds
- Water heater at <120º

HEARING CHECKLIST FOR PARENTS (OPTIONAL)

	Yes	No	
Ages Birth to 3 months	○	○	Gives a startle response to loud, sudden noises within 3 feet
	○	○	Calms to a familiar, friendly voice
	○	○	Wakes up when you speak or make noise nearby
	○	○	Coos and gurgles
	○	○	Laughs and uses voice when playing
	○	○	Watches your face when spoken to

EARLY CHILDHOOD INTERVENTION (ECI)

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