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