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

Texas Health Steps

CHILD HEALTH RECORD

7 YEAR 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: Y ☐ N ☐
Findings:

☐ TB questionnaire*, risk identified: Y ☐ N ☐
**Tuberculin Skin Test if indicated* ☐ TST
(See back for form)

NUTRITION*:
Problems: Y ☐ N ☐
Assessment:

**See Bright Futures Nutrition Book if needed*

IMMUNIZATIONS

☐ Up-to-date
☐ Deferred - Reason:

Given today: ☐ Hep A ☐ Hep B ☐ IPV ☐ Td/Tdap
☐ Meningococcal* ☐ MMR ☐ MMRV
☐ Pneumococcal* ☐ Varicella ☐ Influenza

**Special populations: See ACIP*

LABORATORY

Tests ordered today:

UNCLOTHED PHYSICAL EXAM

☐ See growth graph

Weight: _____ (_____%) Height: _____ (_____%)
BMI: _____ (_____%) Heart Rate: _____
Blood Pressure: _____/_____ Respiratory Rate: _____
Temperature (optional): _____

☐ Normal (Mark here if all items are WNL)

Abnormal (Mark all that apply and describe):

☐ Appearance	☐ Nose	☐ Lungs
☐ Head	☐ Mouth/throat	☐ GI/abdomen
☐ Skin	☐ Teeth	☐ Extremities
☐ Eyes	☐ Neck	☐ Back
☐ Ears	☐ Heart	☐ Musculoskeletal
		☐ Neurological

Abnormal findings:

Additional:
Tanner Stage
Breasts _____/5 Genitalia _____/5

Subjective Hearing Screening: P ☐ F ☐
Subjective Vision Screening: P ☐ F ☐

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

☐ Selected health topics addressed in any of the following areas*:

- School Activity
- Development
- Physical Activity
- Oral Health
- Nutrition
- Safety

**See Bright Futures for assistance*

ASSESSMENT

PLAN/REFERRALS

Dental Referral: Y ☐
Other Referral(s)

Return to office: _____

Signature/title

Signature/title