13 Months – 2 Years

Texas Department of Health
Child Health Record
Preventive Health Visit

Client Information

Name: _____
DOB: _____ /_____/ _____ Age: _____ Sex: _____
SSN/Record No.: _____
Race/Ethnicity: _____
Informant/Relationship: _____
Medical Home: _____

Family Profile and Health

____ No change in household since last visit
Child lives with:
____ Mother ____ Father ___ Stepparent ____ Grandparent
____ Other
Total adults living in home: _____
Total children living in home: _____
Primary caretaker for this child: _____
Relationship: _____
Family's concerns/problems:

Development

Parent's concerns:

Developmental Assessment: ____ P ____ F
Type of Developmental Screen:
Standardized Parent Questionnaire: _____
Standardized Observational Screen: _____
Other: _____
Further assessment needed: ____ Y ____ N
Mental Health (see "Key Elements" on reverse side):

Child's Health

Allergies:
Does the system review note any problems or parent concerns: ____Y ____N
Explain:
Major illness, injury, hospitalization, surgery (since last visit):

Medications taken regularly – Type/Reason:

Dental Care:

Physical Examination

Temp _____ Pulse _____ Resp _____
FOC _____ Height _____ Weight _____
(%) _____ (%) _____ (%) _____

N	A	NE		N	A	NE	
__	__	__	Appearance	__	__	__	Heart/pulses
__	__	__	Head/fontanels	__	__	__	Lungs
__	__	__	Skin/nodes	__	__	__	Abdomen
__	__	__	Eyes	__	__	__	Genitalia/anus
__	__	__	Ears	__	__	__	Spine/hips
__	__	__	Nose	__	__	__	Extremities
__	__	__	Mouth/throat	**Neurologic:**			
__	__	__	Teeth	__	__	__	Muscle tone
__	__	__	Neck	__	__	__	DTRs
__	__	__	Chest/breasts				

Additional documentation:

Nutrition

Problems: special diet, inappropriate weight gain, anemic, chronic GI problems, major food allergies, refusal of any food group, developmental* ____Y ____N
**If answered yes, further assessment needed.*
Usual Servings Per Day:
__ Dairy __ Formula __ Breast __ Vegetables WIC: __Y __N
__ Breads, cereal, rice, and pasta
__ Meat, poultry, fish, eggs, and dry beans
__ Fruits

Sensory

Vision Screen: ____ Normal ____ Abnormal
Hearing Screen: ____ Normal ____ Abnormal
Screen used: ____ TDH Hearing Checklist

Health Education

Injury Prevention
__ Car safety restraints
__ Choking, unsafe toys
__ Poisoning
__ Burns
__ Water safety/temp
__ Supervised play
__ Electrical injury
__ Passive smoking

Behavior
__ Parent/infant interaction
__ Social interaction
__ Limit TV
__ Set limits
__ Sibling rivalry
__ Toilet training

Health Promotion
__ Immunizations
__ Smoking in home
__ Well-child care
__ Dental care, appointment
__ Family planning
__ Daycare

Nutrition
__ Healthy diet/snacks
__ Iron-rich foods
__ Physical activity
__ Weaning
__ Off bottle by age 1

Assessment

Plan

Dental referral made: __ Y __ N
WIC: __ Referred __ Refused __ N/A
Immunizations: __ Up to date __ To be given today __ Deferred
Explain:
Lab:
Hct/Hgb _____ Lead _____
Hep C (if 12 months old or older and born to HCV infected woman) _____
Next appointment:

Date: _____ Signature/Title: _____ Signature/Title _____

C.14 Hearing Checklist for Parents

Hearing Checklist for Parents

Client Information

Name: _____

DOB: ____/____/____ Age: _____ Sex: _____

SSN/Record No.: _____

Race/Ethnicity: _____

Informant/Relationship: _____

Medical Home: _____

Age 0 to 3 Yrs	Yes	No	
0 to 3 months	❑	❑	Does your baby get quiet for a moment when you talk to him/her?
	❑	❑	Does your baby act startled or stop moving for a moment when there are sudden loud noises?
4 to 6 months	❑	❑	Does your baby turn his/her eyes or head to the sound of your voice if he/she cannot see you?
	❑	❑	Does your baby smile or stop crying when you or someone else he/she knows speaks?
7 to 9 months	❑	❑	Does your baby stop and pay attention when you say "no" or call his/her name?
	❑	❑	Does your baby move his/her head around to try and find out where a new sound is coming from?
	❑	❑	Does your baby make strings of sounds ("ba ba ba, da da da")?
10 to 15 months	❑	❑	Does your baby give you toys or other objects (bottle) when you ask, without your having to use a gesture (holding out your hand or pointing)?
	❑	❑	Does your baby point to familiar objects if you ask ("dog," "light")?
16 to 24 months	❑	❑	Does your child use his/her voice most of the time to get what he/she wants or to communicate with you?
	❑	❑	Can your child go get familiar objects that are kept in a regular place if you ask him/her ("Get your shoes.")?
25 to 36 months	❑	❑	Does your child answer different kinds of questions ("When...," "Who...," "What...,")?
	❑	❑	Does your child notice different sounds (telephone ringing, shouting, doorbell)?

If you answered "no" to any of the above questions, ask your doctor about a hearing test for your baby. Babies can be tested as soon as the day of birth.

Date of visit	Age	Result	Signature of Provider
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TEXAS Department of State Health Services

Department of State Health Services
Publication No. EFO5-12234
8/05

C.11 24-Hour Dietary Recall and Assessment for Children (1–4 Years) (2 Pages)

24-Hour Dietary Recall and Assessment for Children 1 Through 4 Years

Name _____
DOB _____ Age _____
SSN/Record No. _____
Required for Child Health

Medical Risks

*Is child underweight or overweight, or does child have poor growth? _____ ☐ Yes ☐ No
If yes, list: _____
*Does child have anemia? _____ ☐ Yes ☐ No
*Does child have lead poisoning? _____ ☐ Yes ☐ No
*Does child have chronic vomiting, diarrhea, or constipation? _____ ☐ Yes ☐ No
If yes, list: _____

Resources

Working stove and refrigerator? _____ ☐ Yes ☐ No
☐ WIC ☐ Food Stamps
☐ Meals in child care ☐ Head Start
☐ Summer food program ☐ Food pantry or soup kitchen
Do you need help in obtaining food? _____ ☐ Yes ☐ No

Feeding Skills

Is child weaned from bottle by 18 months? _____ ☐ Yes ☐ No
Is child able to feed self after 2 years? _____ ☐ Yes ☐ No ☐ N/A
*Does child have any feeding problems? _____ ☐ Yes ☐ No
Check all that apply:
☐ sucking ☐ chewing ☐ choking
☐ swallowing ☐ gagging ☐ other (specify): _____

Dietary Practices

*Is child on a therapeutic or special diet? _____ ☐ Yes ☐ No
If yes, describe: _____ Prescribed by: _____
*Any major food allergies? _____ ☐ Yes ☐ No
If yes, list: _____ Symptoms: _____
*Any food groups refused or omitted? _____ ☐ Yes ☐ No
If yes, list: _____
Does child eat dirt, clay, paint chips, or other non-foods? _____ ☐ Yes ☐ No
Does child under 3 eat hot dogs, grapes, nuts, popcorn, or hard candies? _____ ☐ Yes ☐ No ☐ N/A
Does child or family eat or avoid any special foods for religious or health reasons? _____ ☐ Yes ☐ No
If yes, describe: _____

Health Habits

Hours of TV per day: _____
How many minutes per day is child physically active? _____
What type of activity? _____
How many meals given daily? _____
Are meals eaten with family? _____
Are snacks given? _____ ☐ Yes ☐ No
If yes, list: _____ ☐ Yes ☐ No
How many snacks per day, including beverages such as fruit juice, fruit drinks, or sodas? _____
How often do you brush and floss child's teeth? _____
Encouraged to clean plate? _____
Vitamin/mineral pills? _____ ☐ Yes ☐ No
If yes, list brand or type: _____ ☐ Yes ☐ No

*If yes to any of these questions, complete a 24-hour dietary recall.

Recall taken by: _____
Recall assessed by: _____ Date: _____

E13-06-11856 Rev. 8/04 TEXAS

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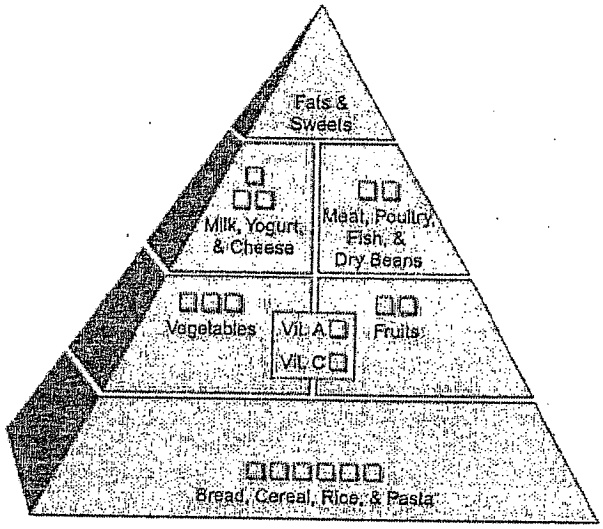
Nutrition Education

- ☐ weaning from bottle
- ☐ foods that cause choking
- ☐ dental health
- ☐ whole milk only (< 2 yrs.)
- ☐ GI disturbances
- ☐ other: _____
- ☐ feeding skills
- ☐ obesity prevention/treatment
- ☐ healthy diet
- ☐ iron-rich foods
- ☐ inadequate/excessive intake of: _____
- ☐ pica / lead poisoning
- ☐ healthy snacks
- ☐ low-fat eating (> 2 yrs.) for heart health
- ☐ physical activity

Date: _____ Counseled by: _____



Minimum Servings

List all foods and beverages consumed in the past 24 hours or previous day.	Amount Consumed

C

TEXAS Department of State Health Services

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C.55 TB Questionnaire

Name of Child_____Date of Birth _____

Organization administering questionnaire_____ Date_____

Tuberculosis (TB) is a disease caused by TB germs and is usually transmitted by an adult person with active TB lung disease. It is spread to another person by coughing or sneezing TB germs into the air. These germs may be breathed in by the child.

Adults who have active TB disease usually have many of the following symptoms: cough for more that two weeks duration, loss of appetite, weight loss of ten or more pounds over a short period of time, fever, chills and night sweats.

A person can have TB germs in his or her body but not have active TB disease (this is called latent TB infection or LTBI).

Tuberculosis is preventable and treatable. TB skin testing (often called the PPD or Mantoux test) is used to see if your child has been infected with TB germs. No vaccine is recommended for use in the United States to prevent tuberculosis. The skin test is not a vaccination against TB.

We need your help to find out if your child has been exposed to tuberculosis.

Place a mark in the appropriate box:	Yes	No	Don't Know
TB can cause fever of long duration, 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? or has your child had any of these symptoms or problems? or has your child been around anyone sick with TB?			
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 recently came to the United States from another country?			

Has your child been tested for TB? Yes___ (if yes, specify date ___/___) No___

Has your child ever had a positive TB skin test? Yes___ (if yes, specify date ___/___) No___

For school/healthcare provider use only

****

PPD administered Yes___ No___

If yes,

Date administered _____/_____/_____ Date read _____/_____/_____ Result of PPD test _____ mm response

Type of service provider (i.e. school, Health Steps, other clinics) _____

PPD provider _____ _____

signature printed name

Provider phone number _____

City _____ County _____

If positive, referral to healthcare provider Yes___ No___

If yes, name of provider _____

EF12-11494 TB Questionnaire for Children (Rev. 08/04)

TEXAS Department of State Health Services

Patient's Name:	DOB:	Medicaid #:
Provider's Name:	Administered by:	Date:

Parent Questionnaire – Risk Assessment for Lead Exposure

		Yes	Don't Know	No
1	Does your child live in or often visit a home, daycare facility, or other building			
	- that was probably built before 1978?			
	- with ongoing repairs or remodeling?			
2	Does your child eat or chew on non-food things like paint chips or dirt?			
3	Does your child reside in a household or has contact with an individual with an elevated blood lead level?			
4	Is your child frequently exposed to any of the following (if YES, check all that apply):			

Perform a Blood Lead Test

Contamination from a parent, relative, or friend with jobs or hobbies like these?

- ❑ Radiator repair
- ❑ Pottery making
- ❑ Lead smelting
- ❑ Welding
- ❑ Making fishing weights
- ❑ House construction or repair
- ❑ Battery manufacture or repair
- ❑ Burning lead-painted wood
- ❑ Automotive repair shop or junkyard
- ❑ Going to a firing range or reloading bullets
- ❑ Chemical preparation
- ❑ Valve and pipe fittings
- ❑ Brass/copper foundry
- ❑ Refinishing furniture
- ❑ Other:

Sources of lead in food and remedies?

- ❑ Imported or glazed pottery such as a Mexican bean pot
- ❑ Imported candy, (like Chaca Chaca) especially from Mexico
- ❑ Nutritional pills other than vitamins
- ❑ Other:
- ❑ Foods canned or packaged outside the U.S.
- ❑ Remedies such as greta, azarcón, alarcón, alkohl, bali goli, coral, ghasard, liga, pay-loo-ah, rueda

Cuestionario de Padre

		Sí	No lo se	No
1	¿Vive su hijo(a) en o visita frecuentemente una casa centro de guardería u otro edificio			
	- que probablemente haya sido construida antes de 1978?			
	- que está siendo pintada, remodelada, o en la que están pelando o lijando la pintura?			
2	¿Su hijo(a) come o mastica cosas que no son comida, como pedazos de pintura or tierra?			
3	¿Han tenido parientes o compañeritos de juego de su hijo(a) altos niveles de plomo en la sangre?			
4	Ha sido expuesto frecuentemente su hijo(a) a cualquier de los siguientes (sí SÍ, marque todos que apliquen:			

La haga al niño una prueba de plomo en el sangre

Contaminación de un padre, pariente, o amigo con trabajos o pasatiempos como estas?

- ❑ Reparación de radiadores
- ❑ Fabricación de cerámica
- ❑ Industria del plomo
- ❑ Soldadura
- ❑ Fabricación de pesas para pescar
- ❑ Construcción o reparación de casas
- ❑ Fabricación o reparación de baterías
- ❑ Quema de madera pintada con plomo
- ❑ Taller mecánico para autos o lote de chatarra
- ❑ Ir a un campo de tiro o recargar balas
- ❑ Preparación de químicos
- ❑ Partes sueltas para tubos de cañerías y válvulas
- ❑ Fundición de latón/cobre
- ❑ Terminado de muebles
- ❑ Otros:

Fuentes de plomo en comidas y remedios?

- ❑ Productos de cerámica importada o con recubrimiento de barniz, como una olla para frijoles de México
- ❑ Productos enlatados o empacados fuera de los Estados Unidos
- ❑ Dulces importados, (como Chaca Chaca) especialmente de México
- ❑ Remedios tradicionales como greta, azarcón, alarcón, alkohl, bali goli, coral, ghasard, liga, pay-loo-ah, rueda
- ❑ Píldoras alimenticias con excepción de las vitaminas
- ❑ Otros:

Fax completed form to 512-458-7699, or mail to address below

Texas Childhood Lead Poisoning Prevention Program
Epidemiology & Surveillance Unit • Texas Department of State Health Services
PO BOX 149347 • Austin, TX 78714-9347

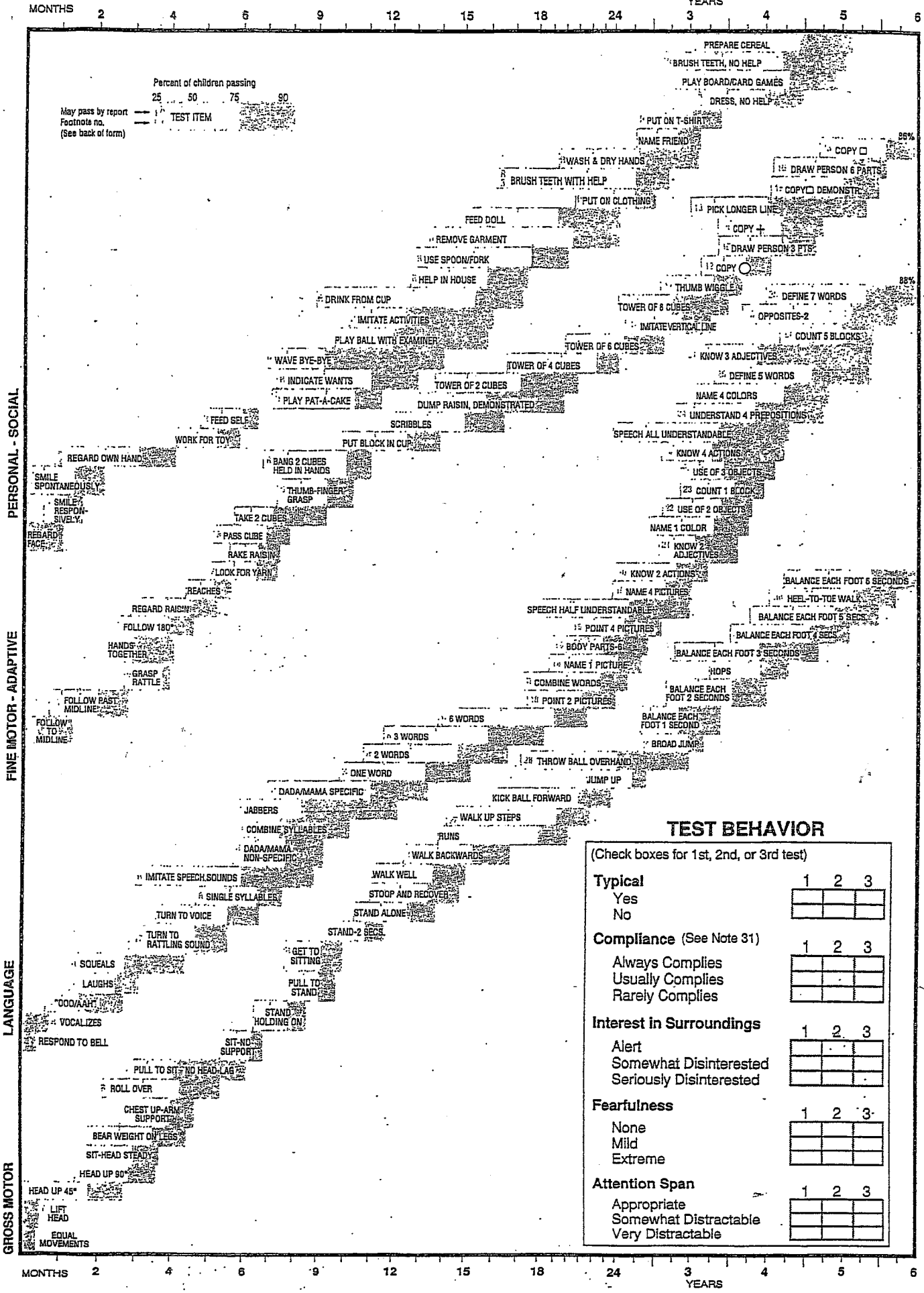
Denver II

Date:

Name:

Birthdate:

ID No.:



TEST BEHAVIOR

(Check boxes for 1st, 2nd, or 3rd test)

	1	2	3
Typical			
Yes			
No			
Compliance (See Note 31)	1	2	3
Always Complies			
Usually Complies			
Rarely Complies			
Interest in Surroundings	1	2	3
Alert			
Somewhat Disinterested			
Seriously Disinterested			
Fearfulness	1	2	3
None			
Mild			
Extreme			
Attention Span	1	2	3
Appropriate			
Somewhat Distractable			
Very Distractable			

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