

3-5 Years

Department of State Health Services Child Health Record Preventive Health Visit

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 Screening: 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 _____
BP _____	Height _____	Weight _____
(%) _____	(%) _____	(%) _____

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

Additional documentation: _____

Client Information

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

Nutrition

Problems: special diet, inappropriate weight gain, anemic, lead poisoning, 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 Vegetables _____ WIC: Y N
 _____ Breads, cereal, rice, and pasta Flouride Supplements: Y N
 _____ Meat, poultry, fish, eggs, and dry beans
 _____ Fruits _____ Vitamins: Y N

Sensory

Vision Screen: _____ Normal _____ Abnormal
Hearing Screen: _____ Normal _____ Abnormal
Hearing Screen Used: _____ Hearing Checklist for Parents

Health Education

Injury Prevention	_____ Toilet training
_____ Car safety restraints	_____ Social interaction
_____ Poisoning	_____ School readiness
_____ Fire safety	_____ Sex education
_____ Firearms	Health Promotion
_____ Street, water, bicycle safety	_____ Immunizations
_____ Scissors/sharp objects	_____ Well-child care
_____ Stranger safety	_____ Dental care, appointment
_____ Teach telephone no. & address	_____ Family planning
_____ Self-safety	_____ Daycare
_____ Passive smoking	Nutrition
Behavior	_____ Healthy diet/snacks
_____ Talk/read with child	_____ Junk food
_____ Exploration	_____ Iron-rich foods
_____ Limit television	_____ Physical activity
_____ Discipline, consistency	

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 _____
Next appointment: _____

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

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

*Does child have any feeding problems? _____ Yes No N/A

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? _____ Yes No

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: _____



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 than 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 _____



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?

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

Sources of lead in food and remedies?

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

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 SI, 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?

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

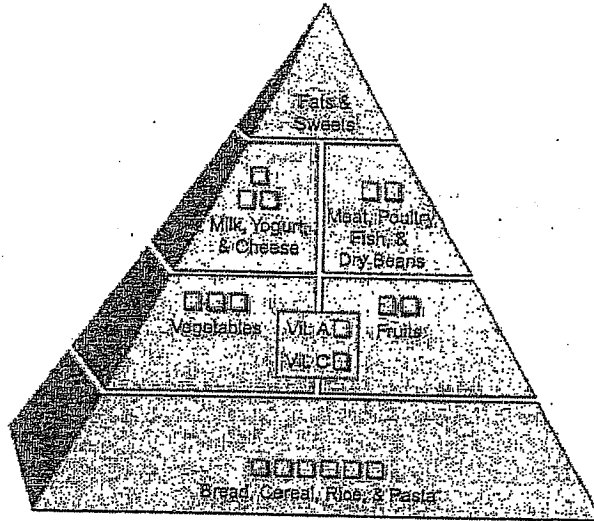
Fuentes de plomo en comidas y remedios?

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

Nutrition Education

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

Date: _____ Counseled by: _____



Minimum Servings

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

C.14 Hearing Checklist for Parents

Hearing Checklist for Parents

Client Information

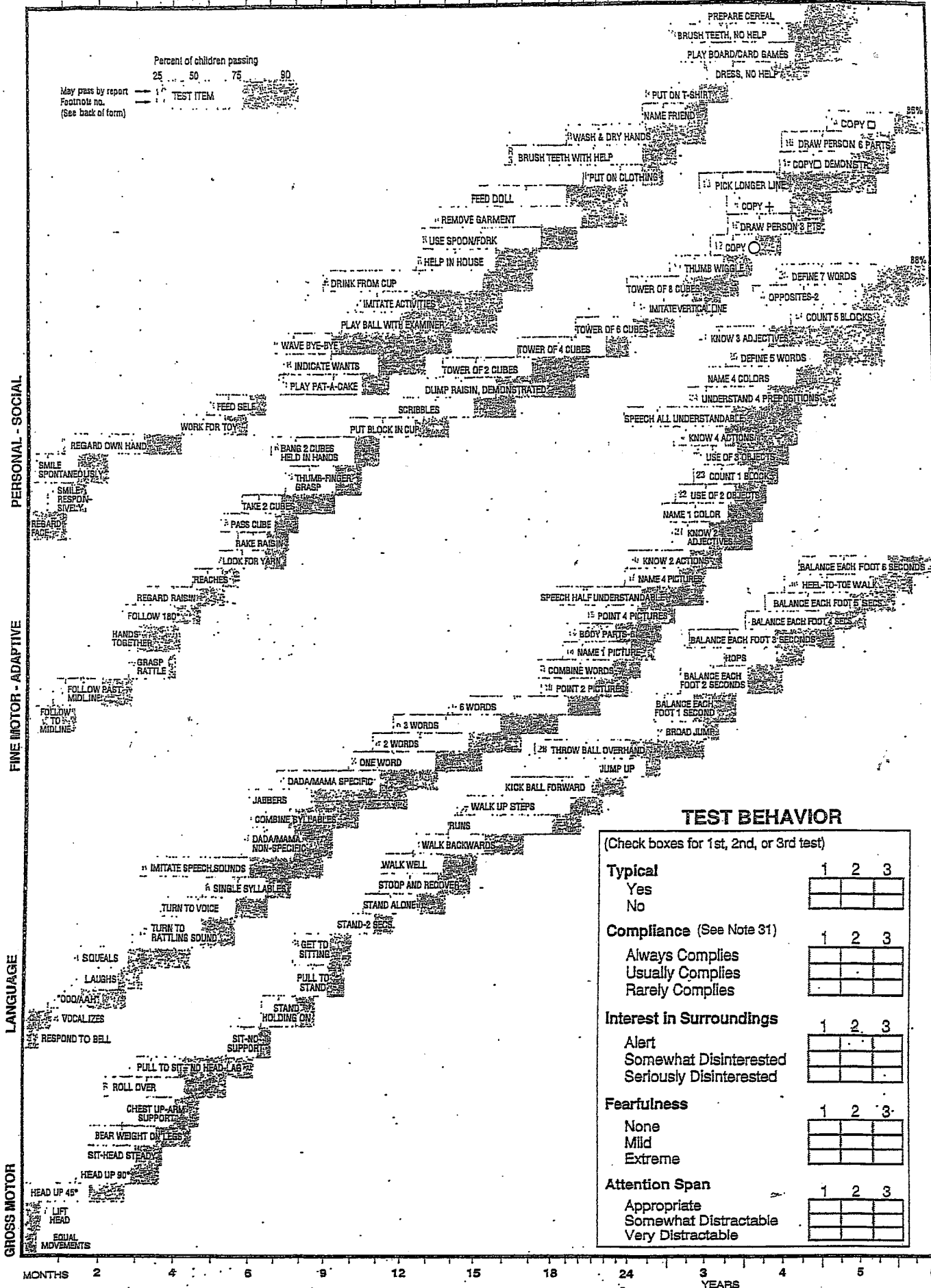
Name: _____
 DOB: ____/____/____ Age: _____ Sex: _____
 SSN/Record No.: _____
 Race/Ethnicity: _____
 Informant/Relationship: _____
 Medical Home: _____

Age 0 to 3 Yrs	Yes	No	
0 to 3 months	<input type="checkbox"/>	<input type="checkbox"/>	Does your baby get quiet for a moment when you talk to him/her?
	<input type="checkbox"/>	<input type="checkbox"/>	Does your baby act startled or stop moving for a moment when there are sudden loud noises?
4 to 6 months	<input type="checkbox"/>	<input type="checkbox"/>	Does your baby turn his/her eyes or head to the sound of your voice if he/she cannot see you?
	<input type="checkbox"/>	<input type="checkbox"/>	Does your baby smile or stop crying when you or someone else he/she knows speaks?
7 to 9 months	<input type="checkbox"/>	<input type="checkbox"/>	Does your baby stop and pay attention when you say "no" or call his/her name?
	<input type="checkbox"/>	<input type="checkbox"/>	Does your baby move his/her head around to try and find out where a new sound is coming from?
	<input type="checkbox"/>	<input type="checkbox"/>	Does your baby make strings of sounds ("ba ba ba, da da da")?
10 to 15 months	<input type="checkbox"/>	<input type="checkbox"/>	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)?
	<input type="checkbox"/>	<input type="checkbox"/>	Does your baby point to familiar objects if you ask ("dog," "light")?
16 to 24 months	<input type="checkbox"/>	<input type="checkbox"/>	Does your child use his/her voice most of the time to get what he/she wants or to communicate with you?
	<input type="checkbox"/>	<input type="checkbox"/>	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	<input type="checkbox"/>	<input type="checkbox"/>	Does your child answer different kinds of questions ("When...", "Who...", "What...")?
	<input type="checkbox"/>	<input type="checkbox"/>	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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Patient name: _____ Date of birth: ____/____/____
 (mo.) (day) (yr.)

Screening Questionnaire for Child and Teen Immunization

For parents/guardians: The following questions will help us determine which vaccines your child may be given today. If you answer "yes" to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't Know
1. Is the child sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the child have allergies to medications, food, a vaccine component, or latex?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the child had a serious reaction to a vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the child had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. If the child to be vaccinated is between the ages of 2 and 4 years, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Does the child have cancer, leukemia, AIDS, or any other immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. In the past 3 months, has the child taken cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Has the child received vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Form completed by: _____ Date: _____

Form reviewed by: _____ Date: _____

Did you bring your child's immunization record card with you? yes no

It is important to have a personal record of your child's vaccinations. If you don't have a personal record, ask the child's healthcare provider to give you one with all your child's vaccinations on it. Keep this record in a safe place and bring it with you every time you seek medical care for your child. Your child will need this important document for the rest of his or her life to enter day care or school, for employment, or for international travel.

Technical content reviewed by the Centers for Disease Control and Prevention, October 2011

www.immunize.org/catg.d/p4060.pdf • Item #P4060 (10/11)