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

3 YEAR 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: Y ☐ N ☐
Findings:

Lead questionnaire, risk identified: Y ☐ N ☐
TB questionnaire*, risk identified: Y ☐ N ☐
* *Tuberculin skin test if indicated* TST ☐
(TB questionnaire-Page 2)

DEVELOPMENTAL/MENTAL HEALTH SCREENING:
Use of standardized tool:
ASQ ☐ ASQ:SE ☐ PEDS ☐ SWYC ☐ P ☐ F ☐

NUTRITION*:
Problems: Y ☐ N ☐
Assessment:

**See Bright Futures Nutrition Book if needed*

IMMUNIZATIONS

☐ Up-to-date
☐ Deferred - Reason:

Given today: ☐ DTaP ☐ HAV ☐ HBV ☐ HIB
☐ Meningococcal ☐ MMR ☐ Pneumococcal ☐ IPV
☐ Varicella ☐ MMR-V ☐ HIB-HBV ☐ DTaP-HIB
☐ DTaP-HB-IPV ☐ DTaP-IPV-HIB ☐ Influenza

LABORATORY

☐ Up-to-date
☐ Deferred - Reason:

Ordered today:

Signature/title

UNCLOTHED PHYSICAL EXAM

☐ See growth graph

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

☐ Normal (Mark here if all items are WNL)

Abnormal (Mark all that apply and describe):

☐ Appearance	☐ Nose	☐ Lungs
☐ Head	☐ Mouth/throat	☐ Abdomen
☐ Skin	☐ Teeth	☐ Genitalia
☐ Eyes	☐ Neurological	☐ Extremities
☐ Ears	☐ Heart	☐ Back
		☐ Musculoskeletal

Abnormal findings:

SENSORY SCREENING:
Visual Acuity Screening:
OD____/____ OS____/____ OU____/____
Hearing Checklist for Parents: P ☐ F ☐
(Hearing Checklist-Page 2)

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

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

- School Readiness
- Development
- Physical Activity
- Nutrition
- Safety

ASSESSMENT

PLAN/REFERRALS

Dental Referral: Y ☐
Other Referral(s)

Return to office:

Signature/title

CHILD HEALTH RECORD

3 YEAR CHECKUP

Name: | Medicaid ID:

Typical Developmentally Appropriate Health Education Topics

3 Year Old Visit

- Lead risk assessment*
- Allow 1:1 time for each child in the family
- Discipline constructively using time-out for 1 minute/year of age
- Encourage child to tell the story his/her way
- Establish routine and assist with tooth brushing with soft brush twice a day
- Limit TV/computer time to 1-2 hours/day
- Maintain consistent family routine
- Provide age-appropriate toys to develop imagination
- Show affection/praise for good behaviors
- Provide nutritious 3 meals and 2 snacks; limit sweets/high-fat foods
- Encourage supervised outdoor exercise
- Lock up guns
- No shaking baby (Shaken Baby Syndrome)
- Provide home safety for fire/carbon monoxide poisoning
- Provide safe/quality after-school care
- Supervise when near or in water even if child knows how to swim
- Teach how to answer the door/telephone
- Use of front-facing car seat until 4 years old and 40 pounds
- Establish consistent bedtime routine
- Establish consistent limits/rules and consistent consequences
- Read books and sing together daily

*See Bright Futures for assistance

HEARING CHECKLIST FOR PARENTS

	Yes	No	
25 to 36 months	☐	☐	Does you child answer different kinds of questions (“When...,” “Who...,” “What...,”)?
	☐	☐	Does you 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.

TB QUESTIONNAIRE

Place a mark in the appropriate box:	Yes	Do not know	No
Has your child been tested for TB?	☐	☐	☐
If yes, when (date)			
Has your child ever had a positive Tuberculin Skin Test?	☐	☐	☐
If yes, when (date)			
TB can cause fever that lasts for days or weeks, 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?	☐	☐	☐
has your child been around anyone sick with TB?	☐	☐	☐
has your child had any of these symptoms or problems?	☐	☐	☐
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 has recently come to the United States from another country?	☐	☐	☐

*LEAD RISK FACTORS

Perform a blood lead test if parent/caretaker answers “Yes/Do not know” to any of the questions below.	Yes	Do not know	No
• Child lives in or visits a home, day care, or other building built before 1978 or undergoing repair	☐	☐	☐
• Pica (Eats non-food items)	☐	☐	☐
• Family member with an elevated blood lead level	☐	☐	☐
• Child is a newly arrived refugee or foreign adoptee	☐	☐	☐
• Exposure to an adult with hobbies or jobs that may have risk of lead contamination (see Pb-110 for a list)	☐	☐	☐
• Food sources (including candy) or remedies (see Pb-110 for a list)	☐	☐	☐
• Imported or glazed pottery	☐	☐	☐
• Cosmetics that may contain lead (see Pb-110 for a list)	☐	☐	☐

The use of Form Pb-110, Lead Risk Questionnaire, is optional. It is available at www.dshs.texas.gov/thsteps/forms.shtm.