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

24 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: Y ☐ N ☐
Findings:

☐ 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 ☐ PEDS ☐ SWYC P ☐ F ☐
Autism screening: ☐ M-CHAT™ ☐ M-CHAT-R/F™ P ☐ F ☐
Findings:

NUTRITION*:
Problems: Y ☐ N ☐
Assessment:

**See Bright Futures Nutrition Book if needed*

IMMUNIZATIONS

☐ Up-to-date
☐ Deferred - Reason:

Given today: ☐ DTaP ☐ Hep A ☐ Hep B ☐ Hib ☐ IPV
☐ Meningococcal* ☐ MMR ☐ Pneumococcal*
☐ Varicella ☐ MMRV ☐ DTaP-IPV-Hep B
☐ DTaP-IPV/Hib ☐ Influenza

**Special populations: See ACIP*

LABORATORY

Tests ordered today:
☐ Blood lead test
Other:

UNCLOTHED PHYSICAL EXAM

☐ See growth graph

Weight: _____ (_____%) Length: _____ (_____%)
BMI: _____ (____%) 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:

SENSORY SCREENING:
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*:

- Communication
- Development/Behaviors
- Social Interaction
- Discipline
- Nutrition
- Safety

**See Bright Futures for assistance*

ASSESSMENT

PLAN/REFERRALS

Dental Referral: Y ☐
Other Referral(s)

Return to office:

Signature/title

Signature/title

Name: | Medicaid ID:

Typical Developmentally Appropriate Health Education Topics

24 Month Checkup

- Assist in use of language to express feelings
- Encourage supervised outdoor exercise
- Establish consistent bedtime routine
- Establish consistent limits/rules and consistent consequences
- Establish routine and assist with tooth brushing with soft brush twice a day
- Limit TV time to 1-2 hours/day
- Maintain consistent family routine
- Progress with toilet training by providing frequent "potty" breaks every 2 hours
- Provide age-appropriate toys to develop imagination/self-expression
- Read books and talk about pictures/story using simple words
- Be aware of language used, child will imitate
- Teach hand-washing
- Discipline constructively using time-out for 1 minute/year of age
- Praise good behavior
- Provide nutritious 3 meals and 2 snacks; limit sweets/high-fat foods
- Lock up guns
- No shaking baby (Shaken Baby Syndrome)
- Provide home safety for fire/carbon monoxide poisoning
- Provide safe/quality day care, if needed
- Supervise within arm's length when near or in water
- Use of front-facing car seat until 4 years old and 40 pounds
- Provide opportunities for side-by-side play with others of same age group
- Use of "No" for self-opinion/frustration/expression of anger

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?	☐	☐	☐

HEARING CHECKLIST FOR PARENTS (OPTIONAL)

	Yes	No	
Ages 18 to 24 months	☐	☐	Understands simple "yes/no" questions
	☐	☐	Understands simple phrases with prepositions ("in the cup")
	☐	☐	Enjoys being read to and points to pictures when asked
	☐	☐	Uses his or her own first name
	☐	☐	Uses "my" to get toys and other objects
	☐	☐	Tells experiences using jargon and words
	☐	☐	Uses 2-word sentences like "my shoes," "go bye-bye," "more juice"

EARLY CHILDHOOD INTERVENTION (ECI)

The ECI Physician Referral and Orders for Early Childhood Intervention (ECI) form is available at:
https://hhs.texas.gov/services/disability/early-childhood-intervention-services/eci-information-health-medical-professionals