4 YEAR CHECKUP CHILD HEALTH RECORD

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

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 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 Hep A Hep B Hib IPV
Meningococcal* MMR Pneumococcal*
Varicella MMRV DTaP-IPV
DTaP-IPV-Hep B DTaP-IPV/Hib Influenza

**Special populations: See ACIP*

LABORATORY

Signature/title

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:

SENSORY SCREENING:

Audiometric Screening:
R 1000Hz________ 2000Hz________ 4000Hz__________
L 1000Hz________ 2000Hz________ 4000Hz__________

Visual Acuity Screening:
OD____/_____ OS____/_____ OU____/_____

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

Selected health topics addressed in any of the following areas*:
- School Readiness/Limitations
- Nutrition
- Personal Hygiene
- Safety

**See Bright Futures for assistance*

ASSESSMENT

PLAN/REFERRALS

Dental Referral: Y
Other Referral(s)

Return to office:

Signature/title

4 YEAR CHECKUP CHILD HEALTH RECORD

Name: | Medicaid ID:

Typical Developmentally Appropriate Health Education Topics

4 Year Old Checkup

- Lead risk assessment*
- Encourage child to tell the story his/her way
- Establish consistent family routine
- Establish daily chores to develop sense of accomplishment and self-confidence
- Limit TV/computer time to 1-2 hours/day
- Show affection/praise for good behaviors
- Provide nutritious 3 meals and 2 snacks; limit sweets/sodas/high-fat foods
- Establish routine and assist with tooth brushing with soft brush twice a day
- Develop a family plan for exiting house in a fire/establish meeting place after exit
- 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 child parents' names/home address/telephone numbers
- Teach how to answer the door/ telephone
- Teach self-safety for personal privacy
- Teach street safety/running after balls/do not cross alone
- Use of booster seat in back seat of car if 40 pounds, until 4ft 9in or 8 years old
- Encourage constructive conflict resolution, demonstrate at home
- Encourage self-dressing and allow to choose own clothing at times
- Encourage supervised outdoor play for 1 hour/day
- Establish consistent bedtime routine
- Establish consistent limits/rules and consistent consequences
- If in pre-school, advocate with teacher for child with school difficulties/bullying
- Read and discuss story daily

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/Don't Know" to any of the questions below.	Yes	Don't 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 the Form Pb-110, Lead Risk Questionnaire is optional. It is available at www.dshs.texas.gov/thsteps/forms.shtm.