

1 to 14 Day Child Health Check-Up Tracking Form

PLEASE PRINT

PERSONAL

Periodic Interperiodic Parent/Caregiver Request

NAME (Last) _____ (First) _____		ID _____	DATE OF BIRTH _____
DATE _____	AGE _____	ACCOMPANIED BY _____	RELATIONSHIP _____

PRENATAL HISTORY

FIRST PRENATAL VISIT DATE _____	ALCOHOL, AMOUNT _____	TOBACCO, AMOUNT _____	STREET DRUGS _____
STDs (specify) _____	HEPATITIS B _____	HIV _____	OTHER MATERNAL PROBLEMS _____
WEEKS GESTATION _____	<input type="checkbox"/> SVD <input type="checkbox"/> CAESAREAN	BIRTH WEIGHT _____	WHERE DELIVERED _____

PERINATAL HISTORY

DEFORMITIES/APGAR _____	ABNORMALITIES _____	OTHER _____	DATE OF D/C - LOS _____
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INTERVAL HISTORY

PAST MEDICAL HISTORY WNL YES NO (IF NO, DESCRIBE)
 DEVELOPMENTAL HISTORY WNL YES NO (IF NO, DESCRIBE)
 BEHAVIORAL HEALTH STATUS WNL YES NO (IF NO, DESCRIBE)

NUTRITIONAL ASSESSMENT

BREAST FORMULA: _____ WIC YES NO REFERRED VITAMINS IRON

PHYSICAL EXAM

HEIGHT _____	WEIGHT _____	HEAD CIRCUMFERENCE _____
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Are the following normal?

	YES	NO	COMMENTS
Appearance			
Skin			
Head			
Eyes			
Ears			
Nose			
Mouth/Throat/Teeth/Gums			
Nodes			
Heart			
Lungs			
Abdomen inc. cord			
Fem. Pulse			
Ext. Gen.			
Hip Abduc.			
Extremities			
Spine			
Neuro			
Other			

LAB TESTS

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SENSORY SCREEN

NORMAL VISION? (red reflex) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED	NORMAL HEARING? (responds to noises, startles) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED
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DEVELOPMENT ASSESSMENT

IS DEVELOPMENT NORMAL FOR AGE AND CULTURE? (prone - lifts head, moves arms/legs equally, Moro reflex)
 YES NO REFERRED

IMMUNIZATIONS

CURRENT DEFERRED PROVIDED: LIST

HEALTH EDUCATION, ANTICIPATORY GUIDANCE

INFANT CAR SEAT "BACK TO SLEEP" OTHER

DIAGNOSIS:
PLAN:
SIGNATURE:

2 Weeks to 2 Month Child Health Check-Up Tracking Form

PLEASE PRINT

PERSONAL

Periodic Interperiodic Parent/Caregiver Request

NAME (Last)	(First)	ID	DATE OF BIRTH
DATE	AGE	ACCOMPANIED BY	RELATIONSHIP

INTERVAL HISTORY

PAST MEDICAL HISTORY WNL YES NO (IF NO, DESCRIBE)

DEVELOPMENTAL HISTORY WNL YES NO (IF NO, DESCRIBE)

BEHAVIORAL HEALTH STATUS WNL YES NO (IF NO, DESCRIBE)

NUTRITIONAL ASSESSMENT

BREAST FORMULA: WIC YES NO REFERRED VITAMINS IRON SOLIDS

PHYSICAL EXAM

HEIGHT	WEIGHT	HEAD CIRCUMFERENCE
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Are the following normal?

	YES	NO	COMMENTS
Appearance			
Skin			
Head			
Eyes			
Ears			
Nose			
Mouth/Throat/Teeth/Gums			
Nodes			
Heart			
Lungs			
Abdomen			
Fem. Pulse			
Ext. Gen.			
Hip Abduc.			
Extremities			
Spine			
Neuro			
Other			

LAB TESTS

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SENSORY SCREEN

NORMAL VISION? (red reflex) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED	NORMAL HEARING? (responds to noises, startles at loud noises) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED
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DEVELOPMENT ASSESSMENT

IS DEVELOPMENT NORMAL FOR AGE AND CULTURE? (prone – lifts head, moves arms/legs equally, regards face, Moro reflex) YES NO REFERRED

IMMUNIZATIONS

CURRENT DEFERRED PROVIDED: LIST

HEALTH EDUCATION, ANTICIPATORY GUIDANCE

INFANT CAR SEAT TALK TO BABY FEVER EDUCATION
 SAFETY – ROLLING OVER OTHER

DIAGNOSIS:
PLAN:
SIGNATURE:

2 to 4 Month Child Health Check-Up Tracking Form

PLEASE PRINT

PERSONAL

Periodic Interperiodic Parent/Caregiver Request

NAME (Last)	(First)	ID	DATE OF BIRTH
DATE	AGE	ACCOMPANIED BY	RELATIONSHIP

INTERVAL HISTORY

PAST MEDICAL HISTORY WNL <input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO, DESCRIBE)
DEVELOPMENTAL HISTORY WNL <input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO, DESCRIBE)
BEHAVIORAL HEALTH STATUS WNL <input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO, DESCRIBE)

NUTRITIONAL ASSESSMENT

<input type="checkbox"/> BREAST	<input type="checkbox"/> FORMULA:	WIC <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED	<input type="checkbox"/> VITAMINS <input type="checkbox"/> IRON <input type="checkbox"/> SOLIDS
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PHYSICAL EXAM

HEIGHT	WEIGHT	HEAD CIRCUMFERENCE
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Are the following normal?

YES NO

COMMENTS

Are the following normal?	YES	NO	COMMENTS
Appearance			
Skin			
Head			
Eyes			
Ears			
Nose			
Mouth/Throat/Teeth/Gums			
Nodes			
Heart			
Lungs			
Abdomen			
Fem. Pulse			
Ext. Gen.			
Hip Abduc.			
Extremities			
Spine			
Neuro			
Other			

LAB TESTS

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SENSORY SCREEN

NORMAL VISION? (red reflex, follows) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED	NORMAL HEARING? (i.e., smiles and/or turns toward speech or sound, coos) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED
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DEVELOPMENT ASSESSMENT

IS DEVELOPMENT NORMAL FOR AGE AND CULTURE? (prone – lifts chest, hands at midline, smiles spontaneously, rolls over one way, grasps rattle)
<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED

IMMUNIZATIONS

<input type="checkbox"/> CURRENT <input type="checkbox"/> DEFERRED <input type="checkbox"/> PROVIDED: LIST
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HEALTH EDUCATION, ANTICIPATORY GUIDANCE

<input type="checkbox"/> SOLID FOODS <input type="checkbox"/> CHOKING, ASPIRATION <input type="checkbox"/> FALLS
<input type="checkbox"/> TEETHING <input type="checkbox"/> BABY-PROOF HOME <input type="checkbox"/> "BACK TO SLEEP"

DIAGNOSIS:

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PLAN:

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SIGNATURE:

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4 to 6 Month Child Health Check-Up Tracking Form

PLEASE PRINT

PERSONAL

Periodic Interperiodic Parent/Caregiver Request

NAME (Last)	(First)	ID	DATE OF BIRTH
DATE	AGE	ACCOMPANIED BY	RELATIONSHIP

INTERVAL HISTORY

PAST MEDICAL HISTORY WNL <input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO, DESCRIBE)
DEVELOPMENTAL HISTORY WNL <input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO, DESCRIBE)
BEHAVIORAL HEALTH STATUS WNL <input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO, DESCRIBE)

NUTRITIONAL ASSESSMENT

<input type="checkbox"/> BREAST	<input type="checkbox"/> FORMULA:	WIC <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED	<input type="checkbox"/> VITAMINS	<input type="checkbox"/> IRON	<input type="checkbox"/> SOLIDS
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PHYSICAL EXAM

HEIGHT	WEIGHT	HEAD CIRCUMFERENCE
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Are the following normal?

	YES	NO	COMMENTS
Appearance			
Skin			
Head			
Eyes			
Ears			
Nose			
Mouth/Throat/Teeth/Gums			
Nodes			
Heart			
Lungs			
Abdomen			
Fem. Pulse			
Ext. Gen.			
Hip Abduc.			
Extremities			
Spine			
Neuro			
Other			

LAB TESTS

<input type="checkbox"/> LEAD SCREEN (blood @ 12 & 24 mo, @ 36-72 mo. if not previously screened; verbal @ 6 mo-6 yrs)	<input type="checkbox"/> OTHER (specify, as indicated)
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SENSORY SCREEN

NORMAL VISION? (red reflex, cover-uncover test, follows) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED	NORMAL HEARING? (i.e., responds to sound, repeats sounds) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED
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DEVELOPMENT ASSESSMENT

IS DEVELOPMENT NORMAL FOR AGE AND CULTURE? (prone-i.e., rolls over, reaches for objects, laughs, squeals)
<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED

IMMUNIZATIONS

<input type="checkbox"/> CURRENT <input type="checkbox"/> DEFERRED <input type="checkbox"/> PROVIDED: LIST
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HEALTH EDUCATION, ANTICIPATORY GUIDANCE

<input type="checkbox"/> CUP, FINGER FOODS	<input type="checkbox"/> NO BOTTLE IN BED	<input type="checkbox"/> TEETHING
<input type="checkbox"/> POOL & TUB SAFETY	<input type="checkbox"/> POISONS	<input type="checkbox"/> OTHER

DIAGNOSIS:
PLAN:
SIGNATURE:

6 to 12 Month Child Health Check-Up Tracking Form

PLEASE PRINT

Periodic Interperiodic Parent/Caregiver Request

PERSONAL			
NAME (Last)	(First)	ID	DATE OF BIRTH
DATE	AGE	ACCOMPANIED BY	RELATIONSHIP

INTERVAL HISTORY

PAST MEDICAL HISTORY WNL	<input type="checkbox"/> YES	<input type="checkbox"/> NO (IF NO, DESCRIBE)
DEVELOPMENTAL HISTORY WNL	<input type="checkbox"/> YES	<input type="checkbox"/> NO (IF NO, DESCRIBE)
BEHAVIORAL HEALTH STATUS WNL	<input type="checkbox"/> YES	<input type="checkbox"/> NO (IF NO, DESCRIBE)

NUTRITIONAL ASSESSMENT

<input type="checkbox"/> BREAST	<input type="checkbox"/> FORMULA:	WIC <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED	<input type="checkbox"/> VITAMINS SOLIDS	<input type="checkbox"/> IRON	<input type="checkbox"/> FLUORIDE	<input type="checkbox"/>
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PHYSICAL EXAM

HEIGHT	WEIGHT	HEAD CIRCUMFERENCE
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Are the following normal?

	YES	NO	COMMENTS
Appearance			
Skin			
Head			
Eyes			
Ears			
Nose			
Mouth/Throat/Teeth/Gums			
Nodes			
Heart			
Lungs			
Abdomen			
Fem. Pulse			
Ext. Gen.			
Hip Abduc.			
Extremities			
Spine			
Neuro			
Other			

LAB TESTS

<input type="checkbox"/> Hgb/Hct _____ (9 mo, adolescent females & as indicated)	<input type="checkbox"/> LEAD SCREEN (blood @ 12 & 24 mo, @ 36-72 mo. if not previously screened; verbal @ 6 mo-6 yrs)	<input type="checkbox"/> OTHER (specify, as indicated)
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SENSORY SCREEN

NORMAL VISION? (red reflex, follows) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED	NORMAL HEARING? (by 9 mo. Turns when called, listens to people talking, enjoys imitating sounds; by 12 mo. Responds to "no", follows simple commands, gives objects upon request, 1-3 words) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED
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DEVELOPMENT ASSESSMENT

IS DEVELOPMENT NORMAL FOR AGE AND CULTURE? (by 9 mo. Plays peek-a-boo, gets to sitting, pulls self to stand, thumb-finger grasp, bangs two toys together; by 12 mo. Play pat-a-cake, neat pincer grasp, stands momentarily, walks holding on, points) YES NO REFERRED

IMMUNIZATIONS

CURRENT DEFERRED PROVIDED: LIST

HEALTH EDUCATION, ANTICIPATORY GUIDANCE

<input type="checkbox"/> BABY-PROOF HOME, POOL	<input type="checkbox"/> SELF-FEEDING	<input type="checkbox"/> TALK TO CHILD
<input type="checkbox"/> TALK TO & NAME OBJECTS	<input type="checkbox"/> SLEEPING	<input type="checkbox"/> DISCIPLINE, PRAISE
<input type="checkbox"/> SHOES-PROTECT, NOT SUPPORT		<input type="checkbox"/> DENTAL HYGIENE
<input type="checkbox"/> SUN PROTECTION	<input type="checkbox"/> OTHER	

DIAGNOSIS:
PLAN:
SIGNATURE:

12 to 18 Month Child Health Check-Up Tracking Form

PLEASE PRINT

PERSONAL

Periodic Interperiodic Parent/Caregiver Request

NAME (Last)	(First)	ID	DATE OF BIRTH
DATE	AGE	ACCOMPANIED BY	RELATIONSHIP

INTERVAL HISTORY

PAST MEDICAL HISTORY WNL YES NO (IF NO, DESCRIBE)

DEVELOPMENTAL HISTORY WNL YES NO (IF NO, DESCRIBE)

BEHAVIORAL HEALTH STATUS WNL YES NO (IF NO, DESCRIBE)

NUTRITIONAL ASSESSMENT

BREAST WHOLE MILK: CUP BOTTLE: TABLE FOODS

WIC YES NO REFERRED VITAMINS IRON FLUORIDE

PHYSICAL EXAM

HEIGHT	WEIGHT	HEAD CIRCUMFERENCE
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Are the following normal?

	YES	NO	COMMENTS
Appearance			
Skin			
Head			
Eyes			
Ears			
Nose			
Mouth/Throat/Teeth/Gums			
Nodes			
Heart			
Lungs			
Abdomen			
Fem. Pulse			
Ext. Gen.			
Hip Abduc. Or Gait			
Extremities			
Spine			
Neuro			
Other			

LAB TESTS

LEAD SCREEN (blood @ 12 & 24 mo, @ 36-72 mo. if not previously screened; verbal @ 6 mo-6 yrs) OTHER (specify, as indicated)

SENSORY SCREEN

NORMAL VISION? (red reflex, follows, cover-uncover) YES NO REFERRED

NORMAL HEARING? (by 12 mo. Responds to "no", follows simple commands, gives objects upon request, 1-3 words; by 18 mo. Reacts to music, points to named objects, 2-3 words other than mama-dada, points to one named body part) YES NO REFERRED

DOES PARENT FEEL SPEECH & HEARING ARE NORMAL FOR AGE? YES NO

DEVELOPMENT ASSESSMENT

IS DEVELOPMENT NORMAL FOR AGE AND CULTURE? (by 12 mo. Play pat-a-cake, neat pincer grasp, stands momentarily, walks holding on, points; by 18 mo. Uses spoon, kicks/throws ball, walks alone)

YES NO REFERRED

IMMUNIZATIONS

CURRENT DEFERRED PROVIDED: LIST

HEALTH EDUCATION, ANTICIPATORY GUIDANCE

SAFETY DISCIPLINE/LIMITS TANTRUMS EATING

SLEEPING READ TO CHILD ASPIRATION NO BOTTLE

SNACKS TOILET TRAINING DENTAL HYGIENE OTHER

SUN PROTECTION SIBLING INTERACTION

DIAGNOSIS:

PLAN:

SIGNATURE:

18 Month to 3 Year Child Health Check-Up Tracking Form

PLEASE PRINT

PERSONAL

Periodic Interperiodic Parent/Caregiver Request

NAME	(Last)	(First)	ID	DATE OF BIRTH
DATE	AGE	ACCOMPANIED BY	RELATIONSHIP	

INTERVAL HISTORY

PAST MEDICAL HISTORY WNL	<input type="checkbox"/> YES	<input type="checkbox"/> NO	(IF NO, DESCRIBE)
DEVELOPMENTAL HISTORY WNL	<input type="checkbox"/> YES	<input type="checkbox"/> NO	(IF NO, DESCRIBE)
BEHAVIORAL HEALTH STATUS WNL	<input type="checkbox"/> YES	<input type="checkbox"/> NO	(IF NO, DESCRIBE)

NUTRITIONAL ASSESSMENT

WNL	<input type="checkbox"/> YES	<input type="checkbox"/> NO	(IF NO, DESCRIBE)	WIC	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> FLUORIDE	<input type="checkbox"/> REFERRED
Referred								

PHYSICAL EXAM

HEIGHT	WEIGHT	HEAD CIRCUMFERENCE
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Are the following normal?

	YES	NO	COMMENTS
Appearance			
Skin			
Head			
Eyes			
Ears			
Nose			
Mouth/Throat/Teeth/Gums			<input type="checkbox"/> DENTAL REFERRAL AGE 3 AND UP REQUIRED
Nodes			
Heart			
Lungs			
Abdomen			
Fem. Pulse			
Ext. Gen.			
Extremities			
Spine			
Neuro			
Other			

LAB TESTS

<input type="checkbox"/> LEAD SCREEN (blood @ 12 & 24 mo, @ 36-72 mo, if not previously screened; verbal @ 6 mo-6 yrs)	<input type="checkbox"/> OTHER (specify, as indicated)
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SENSORY SCREEN

NORMAL VISION? (eyes straight?, red reflex, fixation test, cover-uncover test)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> REFERRED	NORMAL HEARING? (2 yr. Uses some understandable speech, combines 2 words, names objects; 3 yr. Uses 3-4 word sentences)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> REFERRED
DOES PARENT FEEL SPEECH & HEARING ARE NORMAL FOR AGE?				<input type="checkbox"/> YES	<input type="checkbox"/> NO		

DEVELOPMENT ASSESSMENT

IS DEVELOPMENT NORMAL FOR AGE AND CULTURE? (by 18 mo. Uses spoon, kicks/throws ball, walks alone; by 3 years jumps in place, knows name, age, and sex; copies a circle)
<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED

IMMUNIZATIONS

<input type="checkbox"/> CURRENT <input type="checkbox"/> DEFERRED <input type="checkbox"/> PROVIDED: LIST
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HEALTH EDUCATION, ANTICIPATORY GUIDANCE

<input type="checkbox"/> DECREASED APPETITE <input type="checkbox"/> READ TO CHILD <input type="checkbox"/> TOILET TRAINING
<input type="checkbox"/> TEETH BRUSHING <input type="checkbox"/> CONTROL TV VIEWING <input type="checkbox"/> SAFETY-CARS & POOL
<input type="checkbox"/> SUN PROTECTION <input type="checkbox"/> OTHER

DIAGNOSIS:

PLAN:

SIGNATURE:

3 to 5 Year Child Health Check-Up Tracking Form

PLEASE PRINT

PERSONAL

Periodic Interperiodic Parent/Caregiver Request

NAME (Last)	(First)	ID	DATE OF BIRTH
DATE	AGE	ACCOMPANIED BY	RELATIONSHIP

INTERVAL HISTORY

PAST MEDICAL HISTORY WNL YES NO (IF NO, DESCRIBE)
 DEVELOPMENTAL HISTORY WNL YES NO (IF NO, DESCRIBE)
 BEHAVIORAL HEALTH STATUS WNL YES NO (IF NO, DESCRIBE)

NUTRITIONAL ASSESSMENT

WNL YES NO (IF NO, DESCRIBE) WIC Yes No FLUORIDE REFERRED
 Referred

PHYSICAL EXAM

HEIGHT	WEIGHT	BLOOD PRESSURE
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Are the following normal?

	YES	NO	COMMENTS
Appearance			
Skin			
Head			
Eyes			
Ears			
Nose			
Mouth/Throat/Teeth/Gums			<input type="checkbox"/> DENTAL REFERRAL AGE 3 AND UP REQUIRED
Nodes			
Heart			
Lungs			
Abdomen			
Fem. Pulse			
Ext. Gen.			
Extremities			
Spine			
Neuro			
Other			

LAB TESTS

U/A _____ (5 yrs & as indicated) LEAD SCREEN (blood @ 12 & 24 mo, @ 36-72 mo. if not screened; verbal @ 6 mo-6 yrs) OTHER (specify, as indicated)

SENSORY SCREEN

NORMAL VISION? YES NO RESULTS: RIGHT ____ LEFT ____ BOTH ____ NORMAL HEARING? NORMAL ABNORMAL (RIGHT ____ LEFT ____) REFERRED
 REFERRED

DOES PARENT FEEL SPEECH & HEARING ARE NORMAL FOR AGE? YES NO

DEVELOPMENT ASSESSMENT

IS DEVELOPMENT NORMAL FOR AGE AND CULTURE?
 YES NO REFERRED

IMMUNIZATIONS

CURRENT DEFERRED PROVIDED: LIST

HEALTH EDUCATION, ANTICIPATORY GUIDANCE

NO PLAYING WITH MATCHES SEAT BELTS STREET SAFETY
 PRESCHOOL SEXUAL CURIOSITY

DIAGNOSIS:

PLAN:

SIGNATURE:

5 to 9 Year Child Health Check-Up Tracking Form

PLEASE PRINT

PERSONAL

Periodic Interperiodic Parent/Caregiver Request

NAME (Last)	(First)	ID	DATE OF BIRTH
DATE	AGE	ACCOMPANIED BY	RELATIONSHIP

INTERVAL HISTORY

PAST MEDICAL HISTORY WNL YES NO (IF NO, DESCRIBE)

DEVELOPMENTAL HISTORY WNL YES NO (IF NO, DESCRIBE)

BEHAVIORAL HEALTH STATUS WNL YES NO (IF NO, DESCRIBE)

NUTRITIONAL ASSESSMENT

WNL YES NO (IF NO, DESCRIBE) FLUORIDE REFERRED

PHYSICAL EXAM

HEIGHT	WEIGHT	BLOOD PRESSURE
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Are the following normal?

	YES	NO	COMMENTS
Appearance			
Skin			
Head			
Eyes			
Ears			
Nose			
Mouth/Throat/Teeth/Gums			<input type="checkbox"/> DENTAL REFERRAL AGE 3 AND UP REQUIRED
Nodes			
Heart			
Lungs			
Abdomen			
Fem. Pulse			
Ext. Gen.			
Extremities			
Spine			
Neuro			
Other			

LAB TESTS

U/A _____ (5 yrs & as indicated) LEAD SCREEN (blood @ 12 & 24 mo. @ 36-72 mo. if not screened; verbal @ 6 mo-6 yrs) OTHER (specify, as indicated)

SENSORY SCREEN

NORMAL VISION? YES NO RESULTS: RIGHT ____ LEFT ____ BOTH ____ NORMAL HEARING? NORMAL ABNORMAL (RIGHT ____ LEFT ____) REFERRED

DOES PARENT FEEL SPEECH & HEARING ARE NORMAL FOR AGE? YES NO

DEVELOPMENT ASSESSMENT

IS DEVELOPMENT NORMAL FOR AGE AND CULTURE?
 YES NO REFERRED

IMMUNIZATIONS

CURRENT DEFERRED PROVIDED: LIST

HEALTH EDUCATION, ANTICIPATORY GUIDANCE

DENTAL HYGIENE PEER RELATIONS LIMIT SETTING
 NUTRITION COMMUNICATION PARENTAL ROLE MODEL
 REGULAR PHYSICAL ACTIVITY SCHOOL PERFORMANCE
 SAFETY: WATER, SEAT BELTS, SKATE BOARD, BICYCLE

DIAGNOSIS:

PLAN:

SIGNATURE:

9 to 13 Year Child Health Check-Up Tracking Form

PLEASE PRINT

PERSONAL

Periodic Interperiodic Parent/Caregiver Request

NAME (Last)	(First)	ID	DATE OF BIRTH
DATE	AGE	ACCOMPANIED BY	RELATIONSHIP

INTERVAL HISTORY

PAST MEDICAL HISTORY WNL YES NO (IF NO, DESCRIBE)

DEVELOPMENTAL HISTORY WNL YES NO (IF NO, DESCRIBE)

BEHAVIORAL HEALTH STATUS WNL YES NO (IF NO, DESCRIBE)

NUTRITIONAL ASSESSMENT

WNL YES NO (IF NO, DESCRIBE) FLUORIDE REFERRED

PHYSICAL EXAM

HEIGHT	WEIGHT	BLOOD PRESSURE
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Are the following normal?

	YES	NO	COMMENTS
Appearance			
Skin			
Head			
Eyes			
Ears			
Nose			
Mouth/Throat/Teeth/Gums			<input type="checkbox"/> DENTAL REFERRAL AGE 3 AND UP REQUIRED
Nodes			
Heart			
Lungs			
Abdomen			
Fem. Pulse			
Ext. Gen.			Tanner Staging:
Extremities			
Spine			
Neuro			
Other			

LAB TESTS

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SENSORY SCREEN

NORMAL VISION? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED RESULTS: RIGHT ____ LEFT ____ BOTH ____	NORMAL HEARING? <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL (RIGHT ____ LEFT ____) <input type="checkbox"/> REFERRED
DOES PARENT FEEL SPEECH & HEARING ARE NORMAL FOR AGE? <input type="checkbox"/> YES <input type="checkbox"/> NO	

DEVELOPMENT ASSESSMENT

IS DEVELOPMENT NORMAL FOR AGE AND CULTURE?
 YES NO REFERRED

IMMUNIZATIONS

CURRENT DEFERRED PROVIDED: LIST

HEALTH EDUCATION, ANTICIPATORY GUIDANCE

DENTAL HYGIENE SEXUAL INFO BICYCLE SAFETY
 PEER PRESSURE NUTRITION COMMUNICATION AFFECTION
 SCHOOL PERFORMANCE SMOKING, ALCOHOL, DRUGS OTHER

DIAGNOSIS:
PLAN:
SIGNATURE:

13 to 21 Year Child Health Check-Up Tracking Form

PLEASE PRINT

PERSONAL

Periodic Interperiodic Parent/Caregiver Request

NAME (Last)	(First)	ID	DATE OF BIRTH
DATE	AGE	ACCOMPANIED BY	RELATIONSHIP

INTERVAL HISTORY

PAST MEDICAL HISTORY WNL YES NO (IF NO, DESCRIBE)

DEVELOPMENTAL HISTORY WNL YES NO (IF NO, DESCRIBE)

BEHAVIORAL HEALTH STATUS WNL YES NO (IF NO, DESCRIBE)

NUTRITIONAL ASSESSMENT

WNL YES NO (IF NO, DESCRIBE) FLUORIDE REFERRED

PHYSICAL EXAM

HEIGHT	WEIGHT	BLOOD PRESSURE
--------	--------	----------------

Are the following normal?

	YES	NO	COMMENTS
Appearance			
Skin			
Head			
Eyes			
Ears			
Nose			
Mouth/Throat/Teeth/Gums			<input type="checkbox"/> DENTAL REFERRAL AGE 3 AND UP REQUIRED
Nodes			
Heart			
Lungs			
Abdomen			
Fem. Pulse			
Ext. Gen.			Tanner Staging:
Extremities			
Spine			
Neuro			
Other			

LAB TESTS

Hgb/Hct _____ (9 mo, adolescent females & as indicated) OTHER (specify, as indicated)

SENSORY SCREEN

NORMAL VISION? YES NO RESULTS: RIGHT _____ LEFT _____ BOTH _____ NORMAL HEARING? NORMAL ABNORMAL (RIGHT _____ LEFT _____) REFERRED

DEVELOPMENT ASSESSMENT

IS DEVELOPMENT NORMAL FOR AGE AND CULTURE?
 YES NO REFERRED

IMMUNIZATIONS

CURRENT DEFERRED PROVIDED: LIST

HEALTH EDUCATION, ANTICIPATORY GUIDANCE

CAR/SEAT BELT SAFETY SEXUAL ED & STDs PHYSICAL ACTIVITY
 PREGNANCY PREVENTION NUTRITION COMM. AFFECTION
 MOTORCYCLE/ HELMET SAFETY SMOKING, ALCOHOL, DRUGS
 SCHOOL PERFORMANCE BREAST OR TESTICULAR SELF-EXAM

DIAGNOSIS:

PLAN:

SIGNATURE: