6 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 SURVEILLANCE:
- Communication skills/language development
- Self-help/care skills
- Social, emotional development
- Cognitive development
- Mental health

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 Influenza

**Special populations: See ACIP*

LABORATORY

Tests ordered today:

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 Activities
- Development
- Physical Activities
- Nutrition
- Safety

**See Bright Futures for assistance*

ASSESSMENT

PLAN/REFERRALS

Dental Referral: Y
Other Referral(s)

Return to office: _______

Signature/title

6 YEAR CHECKUP CHILD HEALTH RECORD

Name:	Medicaid ID:

Typical Developmentally Appropriate Health Education Topics

6 Year Old Checkup

- Lead risk assessment*
- Encourage child to tell the story his/her way
- Encourage constructive conflict resolution, demonstrate at home
- Establish consistent bedtime routine
- Establish consistent limits/rules and consistent consequences
- Establish daily chores to develop sense of accomplishment and increase self-confidence
- 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
- Read and discuss story daily
- Show affection/praise for good behaviors
- Provide nutritious 3 meals and 2 snacks; limit sweets/sodas/high-fat foods
- During sports wear protective gear at all times
- Encourage supervised outdoor play for 1 hour/day
- Develop a family plan for exiting house in a fire/establish meeting place after exit
- Lock up guns
- 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
- Teach self-safety for personal privacy
- Teach street safety/running after balls/crossing street/riding bicycle/boarding bus
- Use of booster seat in back seat of car until 4ft 9in or 8 years old
- Advocate with teacher for child with school difficulties/bullying
- Discuss school activities 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.