

## 2 to 4 Days Child Health Check-Up Tracking Form

PLEASE PRINT

<b>PERSONAL</b>		<input type="checkbox"/> Periodic	<input type="checkbox"/> Interperiodic	<input type="checkbox"/> Parent/Caregiver Request
NAME (Last) (First)		ID	DATE OF BIRTH	
DATE	AGE	ACCOMPANIED BY	RELATIONSHIP	

<b>PRENATAL HISTORY</b>			
FIRST PRENATAL VISIT DATE	ALCOHOL / AMOUNT	TOBACCO / AMOUNT	ILLICIT DRUG USE
STDs (Specify)	HEPATITIS B	HIV	OTHER MATERNAL PROBLEMS
WEEKS GESTATION	<input type="checkbox"/> SVD	<input type="checkbox"/> CAESAREAN	BIRTH WEIGHT
			WHERE DELIVERED

<b>PERINATAL HISTORY</b>			
DEFORMITIES / APGAR	ABNORMALITIES	OTHER	DATE OF D/C - LOS

<b>INITIAL OR INTERVAL HISTORY</b>			
PAST MEDICAL HISTORY	<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)

<b>NUTRITIONAL ASSESSMENT</b>			
<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

<b>PHYSICAL EXAM</b>		
HEIGHT	WEIGHT	HEAD CIRCUMFERENCE

Are the following normal?	Yes	No	Comments
Appearance			
Skin			
Head			
Eyes			
Ears			
Nose			
Mouth/Throat/Teeth/Gums			
Nodes			
Heart			
Lungs			
Abdomen incl. cord			
Femoral Pulse			
External Genitalia			
Hip Abduction			
Extremities			
Spine			
Neuro			
Other			

<b>LAB TESTS</b>
<input type="checkbox"/> [HEREDITARY / METABOLIC SCREENING AS INDICATED OR REQUIRED BY LAW IF NOT DONE PREVIOUSLY (INPATIENT)]

<b>SENSORY SCREEN</b>	
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

<b>DEVELOPMENTAL ASSESSMENT</b>
IS DEVELOPMENT NORMAL FOR AGE AND CULTURE? (prone - lifts head, moves arms/legs equally, moro reflex) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED

<b>IMMUNIZATIONS</b>
<input type="checkbox"/> CURRENT <input type="checkbox"/> DEFERRED <input type="checkbox"/> PROVIDED: LIST

<b>HEALTH EDUCATION, ANTICIPATORY GUIDANCE [Injury Prevention, Violence Prevention, Nutrition Counseling, Sleep Position Counseling]</b>
<input type="checkbox"/> INFANT CAR SEAT <input type="checkbox"/> "BACK TO SLEEP" <input type="checkbox"/> OTHER

<b>DIAGNOSIS:</b>
<b>PLAN:</b>
<b>SIGNATURE:</b>

## By 1 Month Child Health Check-Up Tracking Form

PLEASE PRINT

<b>PERSONAL</b>		<input type="checkbox"/> Periodic	<input type="checkbox"/> Interperiodic	<input type="checkbox"/> Parent/Caregiver Request
NAME (Last) (First)		ID	DATE OF BIRTH	
DATE	AGE	ACCOMPANIED BY	RELATIONSHIP	

**PRENATAL HISTORY [IF NOT DONE PREVIOUSLY]**

FIRST PRENATAL VISIT DATE	ALCOHOL / AMOUNT	TOBACCO / AMOUNT	ILLICIT DRUG USE
STDs (Specify)	HEPATITIS B	HIV	OTHER MATERNAL PROBLEMS
WEEKS GESTATION	<input type="checkbox"/> SVD <input type="checkbox"/> CAESAREAN	BIRTH WEIGHT	WHERE DELIVERED

**PERINATAL HISTORY [IF NOT DONE PREVIOUSLY]**

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

PAST MEDICAL HISTORY	<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
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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 incl. cord			
Femoral Pulse			
External Genitalia			
Hip Abduction			
Extremities			
Spine			
Neuro			
Other			

**LAB TESTS**

<input type="checkbox"/> [HEREDITARY / METABOLIC SCREENING AS INDICATED OR REQUIRED BY LAW IF NOT DONE PREVIOUSLY]
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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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**DEVELOPMENTAL ASSESSMENT**

IS DEVELOPMENT NORMAL FOR AGE AND CULTURE? (prone - lifts head, moves arms/legs equally, moro reflex) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED
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**IMMUNIZATIONS**

<input type="checkbox"/> CURRENT <input type="checkbox"/> DEFERRED <input type="checkbox"/> PROVIDED: LIST
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**HEALTH EDUCATION, ANTICIPATORY GUIDANCE [Injury Prevention, Violence Prevention, Nutrition Counseling, Sleep Position Counseling]**

<input type="checkbox"/> INFANT CAR SEAT <input type="checkbox"/> TALK TO BABY <input type="checkbox"/> FEVER EDUCATION
<input type="checkbox"/> SAFETY-ROLLING OVER <input type="checkbox"/> OTHER

<b>DIAGNOSIS:</b>
<b>PLAN:</b>
<b>SIGNATURE:</b>

## 2 to 4 Months 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	<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 incl. cord			
Femoral Pulse			
External Genitalia			
Hip Abduction			
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? (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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**DEVELOPMENTAL 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
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**IMMUNIZATIONS**

<input type="checkbox"/> CURRENT <input type="checkbox"/> DEFERRED <input type="checkbox"/> PROVIDED: LIST
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**HEALTH EDUCATION, ANTICIPATORY GUIDANCE [Injury Prevention, Violence Prevention, Nutrition Counseling, Sleep Position Counseling]**

<input type="checkbox"/> SOLID FOOD <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"
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<b>DIAGNOSIS:</b>
<b>PLAN:</b>
<b>SIGNATURE:</b>

## 4 to 6 Months Child Health Check-Up Tracking Form

PLEASE PRINT

<b>PERSONAL</b>		<input type="checkbox"/> Periodic	<input type="checkbox"/> Interperiodic	<input type="checkbox"/> Parent/Caregiver Request
NAME (Last) (First)		ID	DATE OF BIRTH	
DATE	AGE	ACCOMPANIED BY	RELATIONSHIP	

**INTERVAL HISTORY**

PAST MEDICAL HISTORY	<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
Are the following normal?      Yes      No      Comments		
Appearance		
Skin		
Head		
Eyes		
Ears		
Nose		
Mouth/Throat/Teeth/Gums		
Nodes		
Heart		
Lungs		
Abdomen incl. cord		
Femoral Pulse		
External Genitalia		
Hip Abduction		
Extremities		
Spine		
Neuro		
Other		

**LAB TESTS**

<input type="checkbox"/> LEAD SCREEN (verbal risk assessment at 6 mos.-6 years)	<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? (responds to sound, repeats sounds): <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED
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**DEVELOPMENTAL ASSESSMENT**

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

<input type="checkbox"/> CURRENT <input type="checkbox"/> DEFERRED <input type="checkbox"/> PROVIDED: LIST
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**HEALTH EDUCATION, ANTICIPATORY GUIDANCE [Injury Prevention, Violence Prevention, Nutrition Counseling, Sleep Position Counseling]**

<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

<b>DIAGNOSIS:</b>
<b>PLAN:</b>
<b>SIGNATURE:</b>

## 6 to 9 Months Child Health Check-Up Tracking Form

PLEASE PRINT

<b>PERSONAL</b>		<input type="checkbox"/> Periodic	<input type="checkbox"/> Interperiodic	<input type="checkbox"/> Parent/Caregiver Request
NAME (Last)	(First)	ID	DATE OF BIRTH	
DATE	AGE	ACCOMPANIED BY	RELATIONSHIP	

**INTERVAL HISTORY**

PAST MEDICAL HISTORY	<input type="checkbox"/> YES	<input type="checkbox"/> NO	(IF NO, DESCRIBE) (IF NO, DESCRIBE) (IF NO, DESCRIBE) (FORM USED AND BRIEF DESCRIPTION) [NOTE THAT PRACTITIONERS ARE REQUIRED TO USE AN ACCEPTABLE DEVELOPMENTAL SCREENING ASSESSMENT TOOL AT THE 9 MONTH, 18 MONTH, 2 YEAR AND 3 YEAR VISITS]
DEVELOPMENTAL HISTORY WNL	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
BEHAVIORAL HEALTH STATUS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
WNL			

**NUTRITIONAL ASSESSMENT**

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

HEIGHT	WEIGHT	HEAD CIRCUMFERENCE	
<b>Are the following normal?</b>	Yes	No	Comments
Appearance			
Skin			
Head			
Eyes			
Ears			
Nose			
Mouth/Throat/Teeth/Gums			
Nodes			
Heart			
Lungs			
Abdomen incl. cord			
Femoral Pulse			
External Genitalia			
Hip Abduction			
Extremities			
Spine			
Neuro			
Other			

**LAB TESTS**

<input type="checkbox"/> Hgb/Hct _____ (9 months, adolescent females, and as indicated)	<input type="checkbox"/> LEAD SCREEN (blood at 12 & 24 months, at 36-72 months if not previously screened, verbal risk assessment at 6 mos.-6 years)	<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 months, turns when called, listens to people talking, enjoys imitating sounds; by 12 months, responds to "no", follows simple commands, gives objects upon requests, 1-3 words): <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED
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**DEVELOPMENTAL ASSESSMENT**

IS DEVELOPMENT NORMAL FOR AGE AND CULTURE? (by 9 months, plays peek-a-boo, gets to sitting, pulls self to stand, thumb-finger grasp, bangs two toys together; by 12 months, plays pat-a-cake, neat pincer grasp, stands momentarily, walks holding on, points)

YES  NO  FORM USED (Req. 9 mo., 12 mo., 2 year and 3 year visits)  REFERRED

**IMMUNIZATIONS**

CURRENT  DEFERRED  PROVIDED: LIST

**HEALTH EDUCATION, ANTICIPATORY GUIDANCE** [Injury Prevention, Violence Prevention, Nutrition Counseling]

<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"/> SUN PROTECTION	<input type="checkbox"/> DENTAL HYGIENE	<input type="checkbox"/> OTHER
<input type="checkbox"/> SHOES-PROTECT, NOT SUPPORT		

<b>DIAGNOSIS:</b>
<b>PLAN:</b>
<b>SIGNATURE:</b>

## 9 to 12 Months Child Health Check-Up Tracking Form

PLEASE PRINT

<b>PERSONAL</b>		<input type="checkbox"/> Periodic	<input type="checkbox"/> Interperiodic	<input type="checkbox"/> Parent/Caregiver Request
NAME (Last)	(First)	ID	DATE OF BIRTH	
DATE	AGE	ACCOMPANIED BY	RELATIONSHIP	

**INTERVAL HISTORY**

PAST MEDICAL HISTORY	<input type="checkbox"/> YES	<input type="checkbox"/> NO	(IF NO, DESCRIBE) (IF NO, DESCRIBE) (IF NO, DESCRIBE) (FORM USED AND BRIEF DESCRIPTION) [NOTE THAT PRACTITIONERS ARE REQUIRED TO USE AN ACCEPTABLE DEVELOPMENTAL SCREENING ASSESSMENT TOOL AT THE 9 MONTH, 18 MONTH, 2 YEAR AND 3 YEAR VISITS]
DEVELOPMENTAL HISTORY WNL	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
BEHAVIORAL HEALTH STATUS WNL	<input type="checkbox"/> YES	<input type="checkbox"/> NO	

**NUTRITIONAL ASSESSMENT**

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

HEIGHT	WEIGHT	HEAD CIRCUMFERENCE	
<b>Are the following normal?</b>			
	Yes	No	Comments
Appearance			
Skin			
Head			
Eyes			
Ears			
Nose			
Mouth/Throat/Teeth/Gums			<input type="checkbox"/> DENTAL REFERRAL IF INDICATED AS EARLY AS AGE 1
Nodes			
Heart			
Lungs			
Abdomen incl. cord			
Femoral Pulse			
External Genitalia			
Hip Abduction			
Extremities			
Spine			
Neuro			
Other			

**LAB TESTS**

<input type="checkbox"/> Hgb/Hct ____ (between 9 and 12 months and as indicated)	<input type="checkbox"/> LEAD SCREEN (blood at 12 & 24 months, at 36-72 months if not previously screened, verbal risk assessment at 6 mos.-6 years)	<input type="checkbox"/> OTHER (specify, as indicated)
<input type="checkbox"/> T <sub>b</sub> testing if at risk beginning at age 12 months		

**SENSORY SCREEN**

NORMAL VISION? (red reflex, follows): <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED	NORMAL HEARING? (by 9 months, turns when called, listens to people talking, enjoys imitating sounds; by 12 months, responds to "no", follows simple commands, gives objects upon requests, 1-3 words): <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED
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**DEVELOPMENTAL ASSESSMENT**

IS DEVELOPMENT NORMAL FOR AGE AND CULTURE? (by 9 months, plays peek-a-boo, gets to sitting, pulls self to stand, thumb-finger grasp, bangs two toys together; by 12 months, plays pat-a-cake, neat pincer grasp, stands momentarily, walks holding on, points)

YES  NO  FORM USED (Req. 9 mo., 18 mo., 2 year and 3 year visits)  REFERRED

**IMMUNIZATIONS**

CURRENT  DEFERRED  PROVIDED: LIST

**HEALTH EDUCATION, ANTICIPATORY GUIDANCE [Injury Prevention, Violence Prevention, Nutrition Counseling]**

<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"/> SUN PROTECTION	<input type="checkbox"/> DENTAL HYGIENE	<input type="checkbox"/> OTHER
<input type="checkbox"/> SHOES-PROTECT, NOT SUPPORT		

<b>DIAGNOSIS:</b>
<b>PLAN:</b>
<b>SIGNATURE:</b>

## 12 to 15 Months Child Health Check-Up Tracking Form

PLEASE PRINT

<b>PERSONAL</b>		<input type="checkbox"/> Periodic	<input type="checkbox"/> Interperiodic	<input type="checkbox"/> Parent/Caregiver Request
NAME (Last) (First)		ID	DATE OF BIRTH	
DATE	AGE	ACCOMPANIED BY	RELATIONSHIP	

**INTERVAL HISTORY**

PAST MEDICAL HISTORY	<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"/> WHOLE MILK: <input type="checkbox"/> CUP <input type="checkbox"/> BOTTLE	<input type="checkbox"/> TABLE FOODS	WIC: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED	<input type="checkbox"/> VITAMINS	<input type="checkbox"/> IRON	<input type="checkbox"/> FLUORIDE
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**PHYSICAL EXAM**

HEIGHT	WEIGHT	HEAD CIRCUMFERENCE
Are the following normal?      Yes      No      Comments		
Appearance		
Skin		
Head		
Eyes		
Ears		
Nose		
Mouth/Throat/Teeth/Gums		<input type="checkbox"/> DENTAL REFERRAL IF INDICATED AS EARLY AS AGE 1
Nodes		
Heart		
Lungs		
Abdomen incl. cord		
Femoral Pulse		
External Genitalia		
Hip Abduction		
Extremities		
Spine		
Neuro		
Other		

**LAB TESTS**

<input type="checkbox"/> LEAD SCREEN (blood at 12 & 24 months, at 36-72 months if not previously screened, verbal risk assessment at 6 mos.-6 years)	<input type="checkbox"/> Tb testing if at risk
<input type="checkbox"/> Hgb/Hct _____ (between 9 and 12 months and as indicated)	<input type="checkbox"/> OTHER (specify, as indicated)

**SENSORY SCREEN**

NORMAL VISION? (red reflex, follows, cover-uncover test): <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED	NORMAL HEARING? (by 9 months, turns when called, listens to people talking, enjoys imitating sounds; by 12 months, responds to "no", follows simple commands, gives objects upon requests, 1-3 words): <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED
DOES PARENT FEEL THAT SPEECH AND HEARING ARE NORMAL FOR AGE? <input type="checkbox"/> YES <input type="checkbox"/> NO	

**DEVELOPMENTAL ASSESSMENT**

IS DEVELOPMENT NORMAL FOR AGE AND CULTURE? (by 12 months, plays pat-a-cake, neat pincer grasp, stands momentarily, walks holding on, points; by 18 months, uses spoon, kicks/throws ball, walks alone) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED
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**IMMUNIZATIONS**

<input type="checkbox"/> CURRENT <input type="checkbox"/> DEFERRED <input type="checkbox"/> PROVIDED: LIST
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**HEALTH EDUCATION, ANTICIPATORY GUIDANCE [Injury Prevention, Violence Prevention, Nutrition Counseling]**

<input type="checkbox"/> SAFETY	<input type="checkbox"/> DISCIPLINE LIMITS	<input type="checkbox"/> TANTRUMS	<input type="checkbox"/> EATING
<input type="checkbox"/> SLEEPING	<input type="checkbox"/> READ TO CHILD	<input type="checkbox"/> ASPIRATION	<input type="checkbox"/> NO BOTTLE
<input type="checkbox"/> SNACKS	<input type="checkbox"/> TOILET TRAINING	<input type="checkbox"/> DENTAL HYGIENE	<input type="checkbox"/> OTHER
<input type="checkbox"/> SUN PROTECTION	<input type="checkbox"/> SIBLING INTERACTION		

<b>DIAGNOSIS:</b>
<b>PLAN:</b>
<b>SIGNATURE:</b>

## 15 to 18 Months Child Health Check-Up Tracking Form

PLEASE PRINT

<b>PERSONAL</b>		<input type="checkbox"/> Periodic	<input type="checkbox"/> Interperiodic	<input type="checkbox"/> Parent/Caregiver Request
NAME (Last) (First)		ID	DATE OF BIRTH	
DATE	AGE	ACCOMPANIED BY	RELATIONSHIP	

**INTERVAL HISTORY**

PAST MEDICAL HISTORY	<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	<input type="checkbox"/> YES	<input type="checkbox"/> NO	(IF NO, DESCRIBE)
WNL	(FORM USED AND BRIEF DESCRIPTION)		
[NOTE THAT PRACTITIONERS ARE REQUIRED TO USE AN ACCEPTABLE DEVELOPMENTAL SCREENING ASSESSMENT TOOL AT THE 9 MONTH, 18 MONTH, 2 YEAR AND 3 YEAR VISITS]			

**NUTRITIONAL ASSESSMENT**

<input type="checkbox"/> BREAST <input type="checkbox"/> WHOLE MILK: <input type="checkbox"/> CUP <input type="checkbox"/> BOTTLE	<input type="checkbox"/> TABLE FOODS	WIC: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED	<input type="checkbox"/> VITAMINS <input type="checkbox"/> IRON <input type="checkbox"/> FLUORIDE
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**PHYSICAL EXAM**

HEIGHT	WEIGHT	HEAD CIRCUMFERENCE																																																																												
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;">Are the following normal?</th> <th style="width: 10%;">Yes</th> <th style="width: 10%;">No</th> <th style="width: 20%;">Comments</th> </tr> </thead> <tbody> <tr><td>Appearance</td><td></td><td></td><td></td></tr> <tr><td>Skin</td><td></td><td></td><td></td></tr> <tr><td>Head</td><td></td><td></td><td></td></tr> <tr><td>Eyes</td><td></td><td></td><td></td></tr> <tr><td>Ears</td><td></td><td></td><td></td></tr> <tr><td>Nose</td><td></td><td></td><td></td></tr> <tr><td>Mouth/Throat/Teeth/Gums</td><td></td><td></td><td style="text-align: right;"><input type="checkbox"/> DENTAL REFERRAL IF INDICATED AS EARLY AS AGE 1</td></tr> <tr><td>Nodes</td><td></td><td></td><td></td></tr> <tr><td>Heart</td><td></td><td></td><td></td></tr> <tr><td>Lungs</td><td></td><td></td><td></td></tr> <tr><td>Abdomen incl. cord</td><td></td><td></td><td></td></tr> <tr><td>Femoral Pulse</td><td></td><td></td><td></td></tr> <tr><td>External Genitalia</td><td></td><td></td><td></td></tr> <tr><td>Hip Abduction</td><td></td><td></td><td></td></tr> <tr><td>Extremities</td><td></td><td></td><td></td></tr> <tr><td>Spine</td><td></td><td></td><td></td></tr> <tr><td>Neuro</td><td></td><td></td><td></td></tr> <tr><td>Other</td><td></td><td></td><td></td></tr> </tbody> </table>			Are the following normal?	Yes	No	Comments	Appearance				Skin				Head				Eyes				Ears				Nose				Mouth/Throat/Teeth/Gums			<input type="checkbox"/> DENTAL REFERRAL IF INDICATED AS EARLY AS AGE 1	Nodes				Heart				Lungs				Abdomen incl. cord				Femoral Pulse				External Genitalia				Hip Abduction				Extremities				Spine				Neuro				Other			
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**LAB TESTS**

<input type="checkbox"/> LEAD SCREEN (blood at 12 & 24 months, at 36-72 months if not previously screened, verbal risk assessment at 6 mos.-6 years) <input type="checkbox"/> Hgb/Hct ____ (if at risk, repeat 6 months after first test and annually through ages 2-5 years)	<input type="checkbox"/> Tb testing if at risk <input type="checkbox"/> OTHER (specify, as indicated)
--	--

**SENSORY SCREEN**

NORMAL VISION? (red reflex, follows, cover-uncover test): <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED	NORMAL HEARING? (by 9 months, turns when called, listens to people talking, enjoys imitating sounds; by 12 months, responds to "no", follows simple commands, gives objects upon requests, 1-3 words): <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED
DOES PARENT FEEL THAT SPEECH AND HEARING ARE NORMAL FOR AGE? <input type="checkbox"/> YES <input type="checkbox"/> NO	

**DEVELOPMENTAL ASSESSMENT**

IS DEVELOPMENT NORMAL FOR AGE AND CULTURE? (by 12 months, plays pat-a-cake, neat pincer grasp, stands momentarily, walks holding on, points; by 18 months, uses spoon, kicks/throws ball, walks alone) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> FORM USED (Req. 9 mo., 18 mo., 2 year and 3 year visits) <input type="checkbox"/> REFERRED
--

**IMMUNIZATIONS**

<input type="checkbox"/> CURRENT <input type="checkbox"/> DEFERRED <input type="checkbox"/> PROVIDED: LIST
--

**HEALTH EDUCATION, ANTICIPATORY GUIDANCE [Injury Prevention, Violence Prevention, Nutrition Counseling]**

<input type="checkbox"/> SAFETY	<input type="checkbox"/> DISCIPLINE LIMITS	<input type="checkbox"/> TANTRUMS	<input type="checkbox"/> EATING
<input type="checkbox"/> SLEEPING	<input type="checkbox"/> READ TO CHILD	<input type="checkbox"/> ASPIRATION	<input type="checkbox"/> NO BOTTLE
<input type="checkbox"/> SNACKS	<input type="checkbox"/> TOILET TRAINING	<input type="checkbox"/> DENTAL HYGIENE	<input type="checkbox"/> OTHER
<input type="checkbox"/> SUN PROTECTION	<input type="checkbox"/> SIBLING INTERACTION		

<b>DIAGNOSIS:</b>
<b>PLAN:</b>
<b>SIGNATURE:</b>

## 18 Months to 2 Years Child Health Check-Up Tracking Form

PLEASE PRINT

<b>PERSONAL</b>		<input type="checkbox"/> Periodic	<input type="checkbox"/> Interperiodic	<input type="checkbox"/> Parent/Caregiver Request
NAME (Last)	(First)	ID	DATE OF BIRTH	
DATE	AGE	ACCOMPANIED BY	RELATIONSHIP	

**INTERVAL HISTORY**

PAST MEDICAL HISTORY	<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	<input type="checkbox"/> YES	<input type="checkbox"/> NO	(IF NO, DESCRIBE)
WNL	(FORM USED AND BRIEF DESCRIPTION)		
[NOTE THAT PRACTITIONERS ARE REQUIRED TO USE AN ACCEPTABLE DEVELOPMENTAL SCREENING ASSESSMENT TOOL AT THE 9 MONTH, 18 MONTH, 2 YEAR AND 3 YEAR VISITS]			

**NUTRITIONAL ASSESSMENT**

WNL <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED	WIC: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED	<input type="checkbox"/> FLUORIDE
--	---	-----------------------------------

**PHYSICAL EXAM**

HEIGHT	WEIGHT	HEAD CIRCUMFERENCE
Are the following normal?      Yes      No      Comments		
Appearance		
Skin		
Head		
Eyes		
Ears		
Nose		
Mouth/Throat/Teeth/Gums		<input type="checkbox"/> DENTAL REFERRAL IF INDICATED AS EARLY AS AGE 1
Nodes		
Heart		
Lungs		
Abdomen incl. cord		
Femoral Pulse		
External Genitalia		
Hip Abduction		
Extremities		
Spine		
Neuro		
Other		

**LAB TESTS**

<input type="checkbox"/> LEAD SCREEN (blood at 12 & 24 months, at 36-72 months if not previously screened, verbal risk assessment at 6 mos.-6 years) <input type="checkbox"/> Hgb/Hct _____ (if at risk, repeat 6 months after first test and annually through ages 2-5 years)	<input type="checkbox"/> T <sub>b</sub> testing if at risk, Cholesterol screening if at risk beginning at age 2 <input type="checkbox"/> OTHER (specify, as indicated)
---	---

**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? (at 2 years uses some understandable speech, combines 2 words, names objects; at 3 years uses 3-4 word sentences): <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED
DOES PARENT FEEL THAT SPEECH AND HEARING ARE NORMAL FOR AGE? <input type="checkbox"/> YES <input type="checkbox"/> NO	

**DEVELOPMENTAL ASSESSMENT**

IS DEVELOPMENT NORMAL FOR AGE AND CULTURE? (by 18 months, uses spoon, kicks/throws ball, walks alone; by 3 years jumps in place, knows name, age, and sex, copies a circle)

YES    NO    FORM USED (Req. 9 mo., 18 mo., 2 year and 3 year visits)    REFERRED

**IMMUNIZATIONS**

CURRENT    DEFERRED    PROVIDED: LIST

**HEALTH EDUCATION, ANTICIPATORY GUIDANCE [Injury Prevention, Violence Prevention, Nutrition Counseling]**

<input type="checkbox"/> DECREASED APETITE	<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	

<b>DIAGNOSIS:</b>
<b>PLAN:</b>
<b>SIGNATURE:</b>

## 2 to 3 Years Child Health Check-Up Tracking Form

PLEASE PRINT

<b>PERSONAL</b>		<input type="checkbox"/> Periodic	<input type="checkbox"/> Interperiodic	<input type="checkbox"/> Parent/Caregiver Request
NAME (Last)	(First)	ID	DATE OF BIRTH	
DATE	AGE	ACCOMPANIED BY	RELATIONSHIP	

**INTERVAL HISTORY**

PAST MEDICAL HISTORY	<input type="checkbox"/> YES	<input type="checkbox"/> NO	(IF NO, DESCRIBE) (IF NO, DESCRIBE) (IF NO, DESCRIBE) (FORM USED AND BRIEF DESCRIPTION) [NOTE THAT PRACTITIONERS ARE REQUIRED TO USE AN ACCEPTABLE DEVELOPMENTAL SCREENING ASSESSMENT TOOL AT THE 9 MONTH, 18 MONTH, 2 YEAR AND 3 YEAR VISITS]
DEVELOPMENTAL HISTORY WNL	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
BEHAVIORAL HEALTH STATUS WNL	<input type="checkbox"/> YES	<input type="checkbox"/> NO	

**NUTRITIONAL ASSESSMENT**

WNL <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED	WIC: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED	<input type="checkbox"/> FLUORIDE
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**PHYSICAL EXAM**

HEIGHT	WEIGHT	HEAD CIRCUMFERENCE
<b>Are the following normal?</b>		
	Yes	No
	<b>Comments</b>	
Appearance		
Skin		
Head		
Eyes		
Ears		
Nose		
Mouth/Throat/Teeth/Gums		<input type="checkbox"/> DENTAL REFERRAL REQUIRED ANNUALLY AGE 3 AND UP
Nodes		
Heart		
Lungs		
Abdomen incl. cord		
Femoral Pulse		
External Genitalia		
Hip Abduction		
Extremities		
Spine		
Neuro		
Other		

**LAB TESTS**

<input type="checkbox"/> LEAD SCREEN (blood at 12 & 24 months, at 36-72 months if not previously screened, verbal risk assessment at 6 mos.-6 years) <input type="checkbox"/> Hgb/Hct _____ (if at risk, annually through ages 2-5 years)	<input type="checkbox"/> Tb testing and Cholesterol screening if at risk <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? (at 2 years uses some understandable speech, combines 2 words, names objects; at 3 years uses 3-4 word sentences): <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED
DOES PARENT FEEL THAT SPEECH AND HEARING ARE NORMAL FOR AGE? <input type="checkbox"/> YES <input type="checkbox"/> NO	

**DEVELOPMENTAL ASSESSMENT**

IS DEVELOPMENT NORMAL FOR AGE AND CULTURE? (by 18 months, uses spoon, kicks/throws ball, walks alone; by 3 years jumps in place, knows name, age, and sex, copies a circle)

YES  NO  FORM USED (Req. 9 mo., 18 mo., 2 year and 3 year visits)  REFERRED

**IMMUNIZATIONS**

CURRENT  DEFERRED  PROVIDED: LIST

**HEALTH EDUCATION, ANTICIPATORY GUIDANCE [Injury Prevention, Violence Prevention, Nutrition Counseling]**

<input type="checkbox"/> DECREASED APETITE	<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	

<b>DIAGNOSIS:</b>
<b>PLAN:</b>
<b>SIGNATURE:</b>

### 3 to 4 Years Child Health Check-Up Tracking Form

PLEASE PRINT

<b>PERSONAL</b>		<input type="checkbox"/> Periodic	<input type="checkbox"/> Interperiodic	<input type="checkbox"/> Parent/Caregiver Request
NAME (Last) (First)		ID	DATE OF BIRTH	
DATE	AGE	ACCOMPANIED BY	RELATIONSHIP	

**INTERVAL HISTORY**

PAST MEDICAL HISTORY	<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)
(FORM USED AND BRIEF DESCRIPTION)			
[NOTE THAT PRACTITIONERS ARE REQUIRED TO USE AN ACCEPTABLE DEVELOPMENTAL SCREENING ASSESSMENT TOOL AT THE 9 MONTH, 18 MONTH, 2 YEAR AND 3 YEAR VISITS]			

**NUTRITIONAL ASSESSMENT**

WNL <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED	WIC: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED	<input type="checkbox"/> FLUORIDE
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**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 REFERRALS REQUIRED ANNUALLY AGE 3 AND UP
Nodes		
Heart		
Lungs		
Abdomen incl. cord		
Femoral Pulse		
External Genitalia		
Hip Abduction		
Extremities		
Spine		
Neuro		
Other		

**LAB TESTS**

<input type="checkbox"/> Hgb/Hct ____ (if at risk, annually through ages 2-5 years)	<input type="checkbox"/> LEAD SCREEN (blood at 12 & 24 months, at 36-72 months if not previously screened, verbal risk assessment at 6 mos.-6 years)	<input type="checkbox"/> Tb testing and Cholesterol screening if at risk <input type="checkbox"/> OTHER (specify, as indicated)
---	--	--

**SENSORY SCREEN**

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

**DEVELOPMENTAL ASSESSMENT**

IS DEVELOPMENT NORMAL FOR AGE AND CULTURE?  
 YES  NO  FORM USED (Req. 9 mo., 18 mo., 2 year and 3 year visits)  REFERRED

**IMMUNIZATIONS**

CURRENT  DEFERRED  PROVIDED: LIST

**HEALTH EDUCATION, ANTICIPATORY GUIDANCE [Injury Prevention, Violence Prevention, Nutrition Counseling]**

<input type="checkbox"/> NO PLAYING WITH MATCHES	<input type="checkbox"/> SEAT BELTS	<input type="checkbox"/> STREET SAFETY
<input type="checkbox"/> PRESCHOOL	<input type="checkbox"/> SEXUAL CURIOSITY	<input type="checkbox"/> OTHER

**DIAGNOSIS:**

---

**PLAN:**

---

**SIGNATURE:**

## 4 to 5 Years 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	<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 <input type="checkbox"/> REFERRED	WIC: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED	<input type="checkbox"/> FLUORIDE
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**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 REFERRALS REQUIRED ANNUALLY AGE 3 AND UP
Nodes			
Heart			
Lungs			
Abdomen incl. cord			
Femoral Pulse			
External Genitalia			
Hip Abduction			
Extremities			
Spine			
Neuro			
Other			

**LAB TESTS**

<input type="checkbox"/> U/A (by age 5 years and as indicated)	<input type="checkbox"/> LEAD SCREEN (blood at 12 & 24 months, at 36-72 months if not previously screened, verbal risk assessment at 6 mos.-6 years)	<input type="checkbox"/> Tb testing and Cholesterol screening if at risk
<input type="checkbox"/> Hgb/Hct _____ (if at risk, annually through ages 2-5 years)		<input type="checkbox"/> OTHER (specify, as indicated)

**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"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED <input type="checkbox"/> ABNORMAL      RIGHT _____      LEFT _____
DOES PARENT FEEL THAT SPEECH AND HEARING ARE NORMAL FOR AGE? <input type="checkbox"/> YES <input type="checkbox"/> NO	

**DEVELOPMENTAL ASSESSMENT**

IS DEVELOPMENT NORMAL FOR AGE AND CULTURE? <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
--

**HEALTH EDUCATION, ANTICIPATORY GUIDANCE [Injury Prevention, Violence Prevention, Nutrition Counseling]**

<input type="checkbox"/> NO PLAYING WITH MATCHES	<input type="checkbox"/> SEAT BELTS	<input type="checkbox"/> STREET SAFETY
<input type="checkbox"/> PRESCHOOL	<input type="checkbox"/> SEXUAL CURIOSITY	<input type="checkbox"/> OTHER

<b>DIAGNOSIS:</b>
<b>PLAN:</b>
<b>SIGNATURE:</b>

## 5 to 6 Years Child Health Check-Up Tracking Form

PLEASE PRINT

<b>PERSONAL</b>		<input type="checkbox"/> Periodic	<input type="checkbox"/> Interperiodic	<input type="checkbox"/> Parent/Caregiver Request
NAME (Last) (First)		ID	DATE OF BIRTH	
DATE	AGE	ACCOMPANIED BY	RELATIONSHIP	

**INTERVAL HISTORY**

PAST MEDICAL HISTORY	<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 <input type="checkbox"/> REFERRED	<input type="checkbox"/> FLUORIDE <input type="checkbox"/> REFERRED
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**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 REFERRALS REQUIRED ANNUALLY
Nodes		
Heart		
Lungs		
Abdomen incl. cord		
Femoral Pulse		
External Genitalia		
Hip Abduction		
Extremities		
Spine		
Neuro		
Other		

**LAB TESTS**

<input type="checkbox"/> U/A (by age 5 years and as indicated)	<input type="checkbox"/> LEAD SCREEN (blood at 12 & 24 months, at 36-72 months if not previously screened, verbal risk assessment at 6 mos.-6 years)	<input type="checkbox"/> Tb testing and Cholesterol screening if at risk
<input type="checkbox"/> Hgb/Hct _____ (if at risk, annually through ages 2-5 years)		<input type="checkbox"/> OTHER (specify, as indicated)

**SENSORY SCREEN**

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

**DEVELOPMENTAL ASSESSMENT**

IS DEVELOPMENT NORMAL FOR AGE AND CULTURE?  <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
--

**HEALTH EDUCATION, ANTICIPATORY GUIDANCE [Injury Prevention, Violence Prevention, Nutrition Counseling]**

<input type="checkbox"/> DENTAL HYGIENE	<input type="checkbox"/> PEER RELATIONS	<input type="checkbox"/> LIMIT SETTING
<input type="checkbox"/> NUTRITION	<input type="checkbox"/> COMMUNICATION	<input type="checkbox"/> PARENTAL ROLE MODEL
<input type="checkbox"/> REGULAR PHYSICAL ACTIVITY	<input type="checkbox"/> SCHOOL PERFORMANCE	
<input type="checkbox"/> SAFETY: WATER, SEAT BELTS, SKATEBOARD, BICYCLE	<input type="checkbox"/> OTHER	

<b>DIAGNOSIS:</b>
<b>PLAN:</b>
<b>SIGNATURE:</b>

## 6 to 8 Years 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	<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 <input type="checkbox"/> REFERRED	<input type="checkbox"/> FLUORIDE <input type="checkbox"/> REFERRED
--	---

**PHYSICAL EXAM**

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

Are the following normal?      Yes      No      Comments

Are the following normal?	Yes	No	Comments
Appearance			
Skin			
Head			
Eyes			
Ears			
Nose			
Mouth/Throat/Teeth/Gums			<input type="checkbox"/> DENTAL REFERRALS REQUIRED ANNUALLY
Nodes			
Heart			
Lungs			
Abdomen incl. cord			
Femoral Pulse			
External Genitalia			
Hip Abduction			
Extremities			
Spine			
Neuro			
Other			

**LAB TESTS**

<input type="checkbox"/> U/A (by age 5 years and as indicated)	<input type="checkbox"/> LEAD SCREEN (blood at 12 & 24 months, at 36-72 months if not previously screened, verbal risk assessment at 6 mos.-6 years)	<input type="checkbox"/> Tb testing and Cholesterol screening if at risk <input type="checkbox"/> OTHER (specify, as indicated)
--	--	--

**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"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED <input type="checkbox"/> ABNORMAL      RIGHT _____      LEFT _____
DOES PARENT FEEL THAT SPEECH AND HEARING ARE NORMAL FOR AGE? <input type="checkbox"/> YES <input type="checkbox"/> NO	

**DEVELOPMENTAL ASSESSMENT**

IS DEVELOPMENT NORMAL FOR AGE AND CULTURE?  <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
--

**HEALTH EDUCATION, ANTICIPATORY GUIDANCE [Injury Prevention, Violence Prevention, Nutrition Counseling]**

<input type="checkbox"/> DENTAL HYGIENE	<input type="checkbox"/> PEER RELATIONS	<input type="checkbox"/> LIMIT SETTING
<input type="checkbox"/> NUTRITION	<input type="checkbox"/> COMMUNICATION	<input type="checkbox"/> PARENTAL ROLE MODEL
<input type="checkbox"/> REGULAR PHYSICAL ACTIVITY	<input type="checkbox"/> SCHOOL PERFORMANCE	
<input type="checkbox"/> SAFETY: WATER, SEAT BELTS, SKATEBOARD, BICYCLE	<input type="checkbox"/> OTHER	

<b>DIAGNOSIS:</b>
<b>PLAN:</b>
<b>SIGNATURE:</b>

## 8 to 10 Years 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	<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 <input type="checkbox"/> REFERRED	<input type="checkbox"/> FLUORIDE <input type="checkbox"/> 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 REFERRALS REQUIRED ANNUALLY
Nodes			
Heart			
Lungs			
Abdomen incl. cord			
Femoral Pulse			
External Genitalia			<input type="checkbox"/> TANNER STAGING: _____
Hip Abduction			
Extremities			
Spine			
Neuro			
Other			

**LAB TESTS**

<input type="checkbox"/> Tb testing and Cholesterol screening if at risk <input type="checkbox"/> OTHER (specify, as indicated)
--

**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"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED <input type="checkbox"/> ABNORMAL      RIGHT _____      LEFT _____
DOES PARENT FEEL THAT SPEECH AND HEARING ARE NORMAL FOR AGE? <input type="checkbox"/> YES <input type="checkbox"/> NO	

**DEVELOPMENTAL ASSESSMENT**

IS DEVELOPMENT NORMAL FOR AGE AND CULTURE?
<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
--

**HEALTH EDUCATION, ANTICIPATORY GUIDANCE** (Injury Prevention, Violence Prevention, Nutrition Counseling)

<input type="checkbox"/> DENTAL HYGIENE	<input type="checkbox"/> SEXUAL INFORMATION	<input type="checkbox"/> BICYCLE SAFETY
<input type="checkbox"/> PEER PRESSURE	<input type="checkbox"/> NUTRITION	<input type="checkbox"/> COMMUNICATION OF AFFECTION
<input type="checkbox"/> SCHOOL PERFORMANCE	<input type="checkbox"/> SMOKING, ALCOHOL, & DRUGS	<input type="checkbox"/> OTHER

<b>DIAGNOSIS:</b>
<b>PLAN:</b>
<b>SIGNATURE:</b>

## 10 to 11 Years 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	<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 <input type="checkbox"/> REFERRED	<input type="checkbox"/> FLUORIDE <input type="checkbox"/> 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 REFERRALS REQUIRED ANNUALLY
Nodes			
Heart			
Lungs			
Abdomen incl. cord			
Femoral Pulse			
External Genitalia			<input type="checkbox"/> TANNER STAGING: _____
Hip Abduction			
Extremities			
Spine			
Neuro			
Other			

**LAB TESTS**

<input type="checkbox"/> Hgb/Hct _____ (at least once by age 13, any member at risk age 11 or over, and annually for menstruating females)	<input type="checkbox"/> T <sub>b</sub> testing and Cholesterol screening if at risk <input type="checkbox"/> OTHER (specify, as indicated)
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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"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED <input type="checkbox"/> ABNORMAL      RIGHT _____      LEFT _____
DOES PARENT FEEL THAT SPEECH AND HEARING ARE NORMAL FOR AGE? <input type="checkbox"/> YES <input type="checkbox"/> NO	

**DEVELOPMENTAL ASSESSMENT**

IS DEVELOPMENT NORMAL FOR AGE AND CULTURE? <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
--

**HEALTH EDUCATION, ANTICIPATORY GUIDANCE [Injury Prevention, Violence Prevention, Nutrition Counseling]**

<input type="checkbox"/> DENTAL HYGIENE <input type="checkbox"/> SEXUAL INFORMATION <input type="checkbox"/> BICYCLE SAFETY <input type="checkbox"/> PEER PRESSURE <input type="checkbox"/> NUTRITION <input type="checkbox"/> COMMUNICATION OF AFFECTION <input type="checkbox"/> SCHOOL PERFORMANCE <input type="checkbox"/> SMOKING, ALCOHOL, & DRUGS <input type="checkbox"/> OTHER
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<b>DIAGNOSIS:</b>
<b>PLAN:</b>
<b>SIGNATURE:</b>

## 11 to 21 Years 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	<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 <input type="checkbox"/> REFERRED	<input type="checkbox"/> FLUORIDE <input type="checkbox"/> REFERRED
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**PHYSICAL EXAM**

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

Are the following normal?      Yes      No      Comments

Are the following normal?	Yes	No	Comments
Appearance			
Skin			
Head			
Eyes			
Ears			
Nose			
Mouth/Throat/Teeth/Gums			<input type="checkbox"/> DENTAL REFERRALS REQUIRED ANNUALLY
Nodes			
Heart			
Lungs			
Abdomen incl. cord			
Femoral Pulse			
External Genitalia			<input type="checkbox"/> TANNER STAGING: _____
Hip Abduction			
Extremities			
Spine			
Neuro			
Other			

**LAB TESTS**

<input type="checkbox"/> Hgb/Hct _____ (adolescent females and as indicated) <input type="checkbox"/> U/A (by age 16 years and as indicated at any time ages 11-21) <input type="checkbox"/> STD Screening in all sexually active patients age ≥11	<input type="checkbox"/> Tb testing and Cholesterol screening if at risk <input type="checkbox"/> Initial Pelvic Exam with Pap Smear all females between ages 18 and 21 <input type="checkbox"/> OTHER (specify, as indicated)
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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"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED <input type="checkbox"/> ABNORMAL      RIGHT      LEFT
DOES PARENT FEEL THAT SPEECH AND HEARING ARE NORMAL FOR AGE? <input type="checkbox"/> YES <input type="checkbox"/> NO	

**DEVELOPMENTAL ASSESSMENT**

IS DEVELOPMENT NORMAL FOR AGE AND CULTURE? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> REFERRED
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**IMMUNIZATIONS**

<input type="checkbox"/> CURRENT <input type="checkbox"/> DEFERRED <input type="checkbox"/> PROVIDED: LIST
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**HEALTH EDUCATION, ANTICIPATORY GUIDANCE [Injury Prevention, Violence Prevention, Nutrition Counseling]**

<input type="checkbox"/> CAR/SEAT BELT SAFETY <input type="checkbox"/> PREGNANCY PREVENTION <input type="checkbox"/> MOTORCYCLE/HELMET SAFETY <input type="checkbox"/> SCHOOL PERFORMANCE	<input type="checkbox"/> SEXUAL ED & STDs <input type="checkbox"/> NUTRITION <input type="checkbox"/> SMOKING, ALCOHOL, & DRUGS <input type="checkbox"/> INSTRUCT ON BREAST OR TESTICULAR SELF-EXAM	<input type="checkbox"/> PHYSICAL ACTIVITY <input type="checkbox"/> COMMUNICATION OF AFFECTION <input type="checkbox"/> OTHER
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<b>DIAGNOSIS:</b>
<b>PLAN:</b>
<b>SIGNATURE:</b>