

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	<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 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)
<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"/> INFANT CAR SEAT <input type="checkbox"/> "BACK TO SLEEP" <input type="checkbox"/> OTHER
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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 <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

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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)	<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

<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
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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
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:
PLAN:
SIGNATURE:

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

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 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) <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

<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 <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	

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

<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, cover-uncover) <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> 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) <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 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)
<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"/> 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
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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"/>	<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 <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
<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 REFERRAL AGE 3 AND UP REQUIRED
Nodes			
Heart			
Lungs			
Abdomen			
Fem. Pulse			
Ext. Gen.			
Extremities			
Spine			
Neuro			
Other			

LAB TESTS

<input type="checkbox"/> U/A _____ (5 yrs & as indicated)	<input type="checkbox"/> LEAD SCREEN (blood @ 12 & 24 mo, @ 36-72 mo. if not screened: verbal @ 6 mo-6 yrs)	<input type="checkbox"/> OTHER (specify, as indicated)
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SENSORY SCREEN

NORMAL <input type="checkbox"/> YES <input type="checkbox"/> NO RESULTS:	NORMAL HEARING? <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL (RIGHT ____ LEFT ____)	<input type="checkbox"/> REFERRED
VISION? <input type="checkbox"/> REFERRED RIGHT ____ LEFT ____ BOTH ____		
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?
<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

<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

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 <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)	<input type="checkbox"/> FLUORIDE	<input type="checkbox"/> REFERRED
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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

<input type="checkbox"/> U/A _____ (5 yrs & as indicated)	<input type="checkbox"/> LEAD SCREEN (blood @ 12 & 24 mo, @ 36-72 mo. if not screened: verbal @ 6 mo-6 yrs)	<input type="checkbox"/> OTHER (specify, as indicated)
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SENSORY SCREEN

NORMAL VISION? <input type="checkbox"/> YES <input type="checkbox"/> NO 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? <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

<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, SKATE BOARD, BICYCLE
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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 <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)	<input type="checkbox"/> FLUORIDE	<input type="checkbox"/> REFERRED
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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 <input type="checkbox"/> YES <input type="checkbox"/> NO RESULTS: VISION? <input type="checkbox"/> REFERRED 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? <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

<input type="checkbox"/> DENTAL HYGIENE <input type="checkbox"/> SEXUAL INFO <input type="checkbox"/> BICYCLE SAFETY <input type="checkbox"/> PEER PRESSURE <input type="checkbox"/> NUTRITION <input type="checkbox"/> COMMUNICATION AFFECTION <input type="checkbox"/> SCHOOL PERFORMANCE <input type="checkbox"/> SMOKING, ALCOHOL, DRUGS <input type="checkbox"/> 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	<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)	<input type="checkbox"/> FLUORIDE	<input type="checkbox"/> REFERRED
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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

<input type="checkbox"/> Hgb/Hct _____ (9 mo, adolescent females & as indicated)	<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"/> NORMAL <input type="checkbox"/> ABNORMAL (RIGHT ____ LEFT ____)	<input type="checkbox"/> REFERRED
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DEVELOPMENT 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

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

DIAGNOSIS:
PLAN:
SIGNATURE: