NAME:
DOB:
GENDER:
DATE OF SERVICE:

MEDICAID ID:
PRIMARY CARE GIVER:
PHONE:
INFORMANT:

Texas Health Steps

15 MONTH VISIT CHILD HEALTH RECORD

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:

☐ Lead questionnaire, risk identified: Y ☐ N ☐
(See back for form)

☐ **DEVELOPMENT:**
- Gross and fine motor development
- Communication skills/language development
- Self-help/care skills
- Social, emotional development
- Cognitive development
- Mental health

NUTRITION*:
☐ Breast ☐ Bottle ☐ Cup
Milk (%): ______________ Ounces per day: ____________
Solid foods: ______________________________
Juice: ______________________________
Water source: ________________ fluoride: Y ☐ N ☐

**See Bright Futures Nutrition Book if needed*

IMMUNIZATIONS

☐ Up-to-date
☐ Deferred - Reason:

Given today: ☐ DTaP ☐ HAV ☐ HBV ☐ HIB ☐ IPV
☐ MMR ☐ Pneumococcal ☐ Varicella ☐ MMR-V
☐ HIB-HBV ☐ DTap-HIB ☐ DTaP-HB-IPV
☐ DTaP-IPV-HIB ☐ Influenza

LABORATORY

☐ Up-to-date
☐ Deferred - Reason:

Ordered today:
Other test results:

Signature/title

UNCLOTHED PHYSICAL EXAM

☐ See growth graph

Weight: ______ (______%) Length: ______ (______%)
Head Circumference: ______ (______%)
Heart Rate: __________ Respiratory Rate: __________
Temperature: __________

☐ Normal (Mark here if all items are WNL)

Abnormal (Mark all that apply and describe):

☐ Appearance	☐ Nose	☐ Abdomen
☐ Head/fontanels	☐ Mouth/throat	☐ Genitalia
☐ Skin	☐ Teeth	☐ Extremities
☐ Eyes	☐ Neurological	☐ Back
☐ Ears	☐ Heart/pulses	☐ Musculoskeletal
	☐ Lungs	☐ Hips

Abnormal findings:

Additional:
Teeth # _______

Subjective Vision Screening: P ☐ F ☐
Hearing Checklist for Parents: P ☐ F ☐
(See back for form)

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

☐ Selected health topics addressed in any of the following areas*:
- Development/Communication
- Behaviors/Discipline
- Routines
- Nutrition
- Safety

ASSESSMENT

PLAN/REFERRALS

Referral(s):

Return to office:

Signature/title

15 MONTH VISIT CHILD HEALTH RECORD

Texas Health Steps

Name: | Medicaid ID:

Typical Developmentally Appropriate Health Education Topics

15 Month Visit

- Encourage supervised outdoor play
- Establish consistent limits/rules and consistent consequences
- Separation anxiety common at this age
- Discipline constructively using time-out for 1 minute/ year of age
- Limit TV time to 1-2 hours/day
- Make 1:1 time for each child in family
- Praise good behavior
- Promote language using simple words
- Provide age-appropriate toys
- Provide favorite toy for self-soothing during sleep time
- Read books and talk about pictures/story using simple words
- Use distraction or choice of 2 appropriate options to avoid/resolve conflicts
- No bottle in bed
- Provide nutritious 3 meals and 2 snacks; limit sweets/ high-fat foods
- Home safety for fire/carbon monoxide poisoning, stair/window gates, electrical outlet covers
- Lock up guns
- No shaking baby (Shaken Baby Syndrome)
- Provide safe/quality day care
- Supervise within arm's length when near water/do not leave alone in bath water
- Use of front-facing car seat in back seat of car if >20 pounds
- Establish consistent bedtime routine
- Establish routine and assist with tooth brushing with soft brush twice a day
- Maintain consistent family routine

**See Bright Futures for assistance*

HEARING CHECKLIST FOR PARENTS

	Yes	No	
Ages 10 to 15 months	☐	☐	Does your baby give you toys or other objects (bottle) when you ask, without your having to use a gesture (holding out your hand or pointing)?
	☐	☐	Does your baby point to familiar objects if you ask ("dog," "light")?

If you answered "no" to any of the above questions, ask your doctor about a hearing test for your baby. Babies can be tested as soon as the day of birth.

Risk Assessment for Lead Exposure: Parent Questionnaire

	Yes	Do not know	No
1 Does your child live in or visit a home, day care, or other building built before 1978?	☐	☐	☐
2 Does your child live in or visit a home, day care, or other building with ongoing repairs or remodeling?	☐	☐	☐
3 Does your child eat or chew on non-food things like paint chips or dirt?	☐	☐	☐
4 Does your child have a family member or friend who has or did have an elevated blood lead level?	☐	☐	☐
5 Is your child a newly arrived refugee or foreign adoptee?	☐	☐	☐
6 Is your child exposed to any of the following (if YES, check all that apply):	☐	☐	☐

If "Yes" or "Do not know" perform a Blood Lead Test

Contamination from a parent, relative, or friend with jobs or hobbies like these?

- ☐ Radiator repair
- ☐ Pottery making
- ☐ Lead smelting
- ☐ Welding
- ☐ Making fishing weights
- ☐ House construction or repair
- ☐ Battery manufacture or repair
- ☐ Burning lead-painted wood
- ☐ Automotive repair shop or junkyard
- ☐ Going to a firing range or reloading bullets
- ☐ Chemical preparation
- ☐ Valve and pipe fittings
- ☐ Brass/copper foundry
- ☐ Refinishing furniture
- ☐ Other:

Sources of lead in food and remedies?

- ☐ Imported or glazed pottery such as a Mexican bean pot
- ☐ Imported candy, (like Chaca Chaca) especially from Mexico
- ☐ Nutritional pills other than vitamins
- ☐ Other:
- ☐ Foods canned or packaged outside the U.S.
- ☐ Remedies such as greta, azarcón, alarcón, alkohl, bali goli, coral, ghasard, liga, pay-loo-ah, rueda

Fax completed form to 512-458-7699, or mail to the address below.

Texas Childhood Lead Poisoning Prevention Program • PO BOX 149347 • Austin, TX 78714-9347 • 1-800-588-1248 • www.dshs.state.tx.us/lead