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Child Health Record

Child's name: _____ Due date/birth date: _____

Gender: _____ Form completion date: _____

Adjusted age of child in months (for children up to 3 years of age who were born preterm): _____

Is this the first Child Health Record? ☐ Yes ☐ No

Pregnancy history

Prenatal

Dates of prenatal care visits to obstetrician: _____

Mother uses/used folic acid supplements during pregnancy?
☐ Yes ☐ No

Frequency of folic acid use (select one):
☐ 2 or fewer times per week ☐ 3 to 4 times per week
☐ 5 or more times per week

Mother uses/used vitamin supplements during pregnancy?
☐ Yes ☐ No

Frequency of vitamin use (select one):
☐ 2 or fewer times per week ☐ 3 to 4 times per week
☐ 5 or more times per week

Baby exposed to neurotoxins before birth? (check all that apply):
☐ Alcohol ☐ Amphetamines ☐ Barbituates ☐ Caffeine ☐ Cocaine/crack ☐ Inhalants ☐ Marijuana
☐ Mercury ☐ Nicotine/cigarettes ☐ Opioids/heroin ☐ Pesticides
☐ Other (please specify): _____

Mother diagnosed with (check all that apply):
☐ Ectopic pregnancy ☐ Gestational diabetes ☐ Low amniotic fluid ☐ Preeclampsia ☐ Placenta previa
☐ Other (please specify): _____

High-risk pregnancy?
☐ Yes ☐ No

Did this pregnancy result in (check one):
☐ Miscarriage ☐ Stillborn birth ☐ Live birth

Pregnancy notes:

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Labor and delivery

Type of delivery: ☐ Caesarean section ☐ Vaginal Difficulty? ☐ Difficulty during labor ☐ Difficulty during delivery

Birth weight: _____ pounds _____ ounces Weeks of gestation (when baby was born): _____

Special conditions at birth (check all that apply):
☐ Congenital heart disease ☐ Jaundice ☐ Spina bifida ☐ Down syndrome ☐ Sickle cell anemia
☐ Other (please specify): _____

Postpartum

Only need to answer if child is 12 months or younger.

Child was breastfed? ☐ Yes ☐ No

If yes: How long was the child breastfed? ☐ Less than 3 months
☐ 3 to 5 months ☐ 6 to 9 months
☐ More than 9 months ☐ Still in progress

Where was breastfeeding initiated?
☐ In the hospital ☐ In the home

Is child exclusively breastfed?
☐ Yes ☐ No

Date(s) of postpartum visit(s):
_____ _____ _____ _____

Health Review

Medical visits and conditions

Dates of well-child visits

5 days		9 months		2.5 years (30 months)	
1 month		12 months		3 years	
2 months		15 months		4 years	
4 months		18 months		5 years	
6 months		2 years (24 months)			

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Immunizations up to date? ☐ Yes ☐ No Date last received immunizations: _____

If not up to date, please specify why not: _____

Primary location for child's regular medical checkups and sick care (select one)**:**

☐ Doctor's/nurse practitioner's office ☐ Hospital emergency room ☐ Hospital outpatient
☐ Federally qualified health center ☐ Retail store or minute clinic ☐ Unknown/did not report ☐ None
☐ Other (please specify): _____

Child has had any illness with high fever (104°F or more) longer than two days. ☐ Yes ☐ No

Medical conditions (check all that apply)**:**

☐ Acquired immunodeficiency syndrome (AIDS)
☐ Asthma and respiratory allergies
☐ Cancer
☐ Cerebral palsy
☐ Cystic fibrosis
☐ Diabetes
☐ Digestion disorders
☐ Emotional/mental health disorders
☐ Feeding difficulties in early childhood
☐ Fetal alcohol spectrum disorder (FASD)
☐ Genetic disorders
☐ Hearing impairment
☐ Heart disease/defects
☐ Human immunodeficiency virus (HIV)
☐ Juvenile arthritis
☐ Overweight and obesity
☐ Prematurity and low birth weight
☐ Sickle cell disease
☐ Spina bifida/neural tube defects
☐ Visual impairment
☐ Other (please specify): _____

Developmental conditions (check all that apply)**:**

☐ Acquired brain injury and selected neurological disorders
☐ Attention deficit hyperactivity disorder (ADHD)
☐ Autism spectrum disorders (ASD)
☐ Communication, language, and speech disorders
☐ Developmental disabilities – not otherwise specified
☐ Disruptive behavior disorders
☐ Learning disabilities
☐ Motor delay and movement disorders
☐ Sensory processing disorder
☐ Other (please specify): _____

Allergies (check all that apply)**:**

☐ Environmental ☐ Food ☐ Medicines ☐ Other (please specify): _____

Child's health insurance (check all that apply)**:**

☐ No insurance coverage ☐ TRICARE ☐ Unknown ☐ No insurance, accessing Indian Health Service
☐ Title XIX (Medicaid/Title XXI – state children's insurance program) ☐ Private or other ☐ Did not report

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Emergency room visits

Date of visit: _____

Reason for visit:
☐ Injury ☐ Illness ☐ Poison
☐ Other (please specify): _____

Referred by health care professional: ☐ Yes ☐ No

Date of visit: _____

Reason for visit:
☐ Injury ☐ Illness ☐ Poison
☐ Other (please specify): _____

Referred by health care professional: ☐ Yes ☐ No

Date of visit: _____

Reason for visit:
☐ Injury ☐ Illness ☐ Poison
☐ Other (please specify): _____

Referred by health care professional: ☐ Yes ☐ No

Date of visit: _____

Reason for visit:
☐ Injury ☐ Illness ☐ Poison
☐ Other (please specify): _____

Referred by health care professional: ☐ Yes ☐ No

Medicines and supplements taken regularly (check all that apply)**:**
☐ Over-the-counter drugs ☐ Ear drops ☐ Vitamin supplements ☐ Antibiotics ☐ Eye ointment
☐ Asthma inhalers ☐ Other (please specify): _____

According to the health care provider, are child's size and weight OK? ☐ Yes ☐ No
If no, please specify concerns about child's size or weight: _____

Child has been screened for anemia? ☐ Yes ☐ No
If yes, please specify results of anemia screening:_____

Child has been screened for lead levels? ☐ Yes ☐ No
If yes, please specify results of lead screening: _____

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Dental review

Brushing teeth, flossing, and/or cleaning gums is part of the child's daily routine? (select one):
☐ Always ☐ Sometimes ☐ Never

Child falls asleep with a bottle? (select one): ☐ Always ☐ Sometimes ☐ Never

Parent has concerns about the child's teeth or gums? ☐ Yes ☐ No
If yes, please specify concerns about teeth or gums: _____

Child has a source of dental care? ☐ Yes ☐ No Child has regular dentist appointments? ☐ Yes ☐ No
Child had his/her first dental appointment? ☐ Yes ☐ No

According to the American Academy of Pediatric Dentistry, a dental home enhances the dental professional's ability to assist children and their parents in the quest for optimum oral health care, beginning with the age 1 dental visit for successful preventive care and treatment as part of an overall oral health care foundation.

Safety review

For children up to 12 months

Does child bed-share? (select one): ☐ Always ☐ Sometimes ☐ Never

Is child placed on his/her back to sleep? (select one): ☐ Always ☐ Sometimes ☐ Never

Is there soft bedding in the area the child sleeps in? (select one): ☐ Always ☐ Sometimes ☐ Never

For all children

Is child exposed to secondhand smoke? (select one): ☐ Always ☐ Sometimes ☐ Never

Notes regarding secondhand smoke exposure: _____

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Safety review (continued)

- ☐ There is at least one working smoke detector on each floor where the family resides.
- ☐ Child rides in an approved car seat according to state law.

  General guidelines: Rear-facing safety seat in the back seat from birth to age 2 and forward-facing safety seat in the back seat until at least age 5.
- ☐ If child is involved in biking, skating, riding a scooter, or similar device, a helmet is used.
- ☐ Home is childproofed (for example, to prevent accidental poisoning, choking, and other injuries).
- ☐ Family has a plan and supplies in case of an emergency in the home or natural disaster.

Date Health Review completed: _____

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Hearing Review

Hearing review

For children up to 12 months (select one):

Child had a new born hearing screening?	☐ Yes	☐ No	☐ Parent/guardian is unsure
If parent/guardian indicates child did not have a new born hearing screening or is unsure, the parent educator should help the parent/guardian follow up.			
If yes: Newborn hearing screening record obtained	☐ Yes	☐ No	
Newborn hearing screening results:	☐ Pass	☐ Fail	☐ Unknown
Newborn hearing screening follow-up recommended?	☐ Yes	☐ No	
Newborn hearing screeing follow-up obtained?	☐ Yes	☐ No	☐ N/A

Additional information: _____

For all children

Child has had ear infections? ☐ Yes ☐ No

If yes, number of ear infections:
☐ 1 or 2 times ☐ 3 or 4 times ☐ 5 or 6 times
☐ 7 or more times

What were the treatments?
☐ Antibiotics ☐ Ear tubes
☐ Other (please specify): _____

Child's hearing has been checked by a health care provider in the last 12 months: ☐ Yes ☐ No

Results of the hearing check: _____

Child has had an audiology exam in the last 12 months:
☐ Yes ☐ No

Date of the latest audiology exam: _____

Who did the audiology exam?
_____

Documentation of the audiology exam obtained?
☐ Yes ☐ No

Results of the audiology exam: _____

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Hearing review (continued)

Answer questions 1 through 8 for children under 2 years; answer questions 6 through 12 for children 2 years and older.

1. Reacts to sudden loud noises.	☐ Yes	☐ No
2. Turns head toward interesting sounds or when name is called.	☐ Yes	☐ No
3. Coos to himself and makes noise when he is alone.	☐ Yes	☐ No
4. Uses voice to get attention.	☐ Yes	☐ No
5. Tries to imitate you if you make his own sounds.	☐ Yes	☐ No
6. Seems to hear you if you talk in a whisper.	☐ Yes	☐ No
7. Seems to speak as well as other children the same age.	☐ Yes	☐ No
8. Has a family history of hearing problems.	☐ Yes	☐ No
9. Seems to have difficulty hearing.	☐ Yes	☐ No
10. Needs the television louder than other members of the family.	☐ Yes	☐ No
11. Seems to favor one ear over the other.	☐ Yes	☐ No
12. Makes you talk loudly or repeat frequently.	☐ Yes	☐ No

A "no" answer for items 1 through 7 indicates the need for discussion and follow-up. A "yes" answer for items 8 through 12 indicates the need for disucession and follow-up.

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Audiology tests (optional)

Screening tool:	**Administered by** (select one)**:**	**Date Completed:**	**Left ear** (select one)**:**	**Right ear** (select one)**:**
OAE	☐ Parent educator ☐ Supervisor ☐ Contracted screener ☐ Health care provider		☐ Can't test ☐ Refer ☐ Pass	☐ Can't test ☐ Refer ☐ Pass
Tympanometry	☐ Parent educator ☐ Supervisor ☐ Contracted screener ☐ Health care provider		☐ Can't test ☐ Refer ☐ Pass	☐ Can't test ☐ Refer ☐ Pass
Audiometry	☐ Parent educator ☐ Supervisor ☐ Contracted screener ☐ Health care provider		☐ Can't test ☐ Refer ☐ Pass	☐ Can't test ☐ Refer ☐ Pass

Note: OAE, tympanometry, and/or audiometry can be beneficial but are not required to meet the PAT Essential Requirements.

Comments/suggestions:

Date Hearing Review completed: _____

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Vision Review

Vision review

Child had an eye exam by a pediatrician, eye doctor, or other qualified professional in the last 12 months? ☐ Yes ☐ No

Date of latest eye exam: _____ Who did the eye exam? _____

Results of the eye exam: _____

Documentation of the eye exam obtained? ☐ Yes ☐ No

The child:

1. Has eye crossed – turning in or out – at any time, or eyes that do not appear straight, especially when child is tired.	☐ Yes	☐ No
2. Has reddened eyes or eyelids.	☐ Yes	☐ No
3. Has encrusted eyelids.	☐ Yes	☐ No
4. Has frequent styes (pimples on the eyelid).	☐ Yes	☐ No
5. Has eyes that appear to move more than other people's eyes do.	☐ Yes	☐ No
6. Has eyelids that droop.	☐ Yes	☐ No
7. Has white spots or cloudiness covering some or all of the center of the eye.	☐ Yes	☐ No
8. Complains of burning, itching, or pain in the eyes.	☐ Yes	☐ No
9. Stares at bright lights frequently or repeatedly flicks objects in front of face.	☐ Yes	☐ No
10. Is bothered by light more than you are.	☐ Yes	☐ No
11. Exhibits a pupil (the dark center of the eye) that seems larger or smaller than the pupil in other children's eyes.	☐ Yes	☐ No
12. Complains of headache or nausea.	☐ Yes	☐ No

A yes answer for any item 1 through 12 indicates the need for discussion and follow-up.

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Vision review (continued)		
13. Has watery eyes.	☐ Yes	☐ No
14. Complains of tired eyes; rubs eyes often.	☐ Yes	☐ No
15. Moves the head forward or backward while looking at distant objects.	☐ Yes	☐ No
16. Turns the head to use one eye only (closes or covers one eye).	☐ Yes	☐ No
17. Tilts the head to use one side often or all the time.	☐ Yes	☐ No
18. Places an object close to the eyes to look at it.	☐ Yes	☐ No
19. Squints while looking at objects.	☐ Yes	☐ No
20. Blinks more than you do.	☐ Yes	☐ No
21. Has difficulty walking or running; trips over objects more often than others do.	☐ Yes	☐ No
22. Is unable to see distant objects.	☐ Yes	☐ No
23. Has a family history of lazy eye or vision problems.	☐ Yes	☐ No
A "yes" answer for three or more items on 13 through 23 indicates the need for discussion and follow-up.		

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Functional vision (optional)

Who administered the screening? (select one):
☐ Parent educator ☐ Supervisor ☐ Contracted screener ☐ Health care provider

Date completed: _____

	Left eye (select one)**:**	**Right eye** (select one)**:**
Blink reflex	☐ Present ☐ Absent	☐ Present ☐ Absent
Pupillary response	☐ Present ☐ Absent	☐ Present ☐ Absent
Corneal light reflex	☐ Present ☐ Absent	☐ Present ☐ Absent
Tracking	☐ Present ☐ Absent	☐ Present ☐ Absent
Reaching	☐ Present ☐ Absent	☐ Present ☐ Absent

Comments/suggestions:

Other screenings (such as acuity screening for children over 2.5 years of age: _____

Date Vision Review completed: _____