

Patient History Form - Newborn to 5 years

Patient Name _____ DOB _____

Sex M F History given by _____ Date _____

Patient Information:

Are immunizations up to date? Yes or No

Birth History: Was infant born early or late? Yes or No

If yes, how many weeks? _____

What was infants birth weight? _____

Did your child have any respiratory problems, jaundice, or other problems at birth?

Acute Illness / Chronic Illness / Medical Issues: List all past and present diagnoses

Hospitalizations or ER Visits: List any that have occurred since the last well check

Surgeries: List any that have occurred since the last well check

Allergies: _____

Medications: name, dose, what is it given for?

Social History:

Who does the patient live with?

If biological parents are separated or don't live in the same home as the patient, how often does the child visit the other home?

Does your child have any pets in or outside of the home? Yes No

If yes, list pets: _____

Does anyone in the household smoke or vape? _____

Any recent travel since the last well check? Yes No Where? _____

Family History - Please provide information for patient's parents, siblings and grandparents:

Heart Problems/ Heart Attack	Y	N	Migraines/Headaches	Y	N	Allergies	Y	N
High Cholesterol	Y	N	ADHD/ADD	Y	N	Eczema	Y	N
High Blood Pressure	Y	N	Diabetes	Y	N	Depression or Anxiety	Y	N
Asthma	Y	N	Thyroid Problems	Y	N	Obesity	Y	N
Stomach Problems	Y	N	Bleeding or Clotting Problems	Y	N	Alcoholism	Y	N
Kidney/Bladder Problems	Y	N	Anemia	Y	N	Drug Abuse	Y	N
Seizures	Y	N	Arthritis	Y	N	Cancer	Y	N



Lead Risk Questionnaire

EPb-110

Purpose: To identify children who need to be tested for lead exposure.

Instructions

- If **Yes or Don't Know**, test the child immediately.
- You may administer a blood lead test instead of using this questionnaire.
- For more information, contact the Texas Childhood Lead Poisoning Prevention Program at: 1-800-588-1248.

Patient's Name: _____ DOB: _____ Medicaid #: _____ Date: _____
 Provider's Name: _____ Administered by: _____

Questions

1. Does your child live in or visit a home, day-care or other building built before 1978? Yes or Don't Know No
2. Does your child live in or visit a home, day-care or other building with ongoing repairs or remodeling? Yes or Don't Know No
3. Does your child eat or chew on non-food things like paint chips or dirt? Yes or Don't Know No
4. Does your child have a family member or friend who has or did have an elevated blood lead level? Yes or Don't Know No
5. Is your child a newly arrived refugee or foreign adoptee? Yes or Don't Know No
6. Does your child come in contact with an adult whose job or hobby involves lead exposure? Yes or Don't Know No

Examples

- House construction or repair
 - Battery manufacturing or repair
 - Burning lead-painted wood
 - Automotive repair shop or junk yard
 - Going to a firing range or reloading bullets
 - Chemical preparation
 - Valve and pipe fittings
 - Brass/copper foundry
 - Refinishing furniture
 - Making fishing weights
 - Radiator repair
 - Pottery making
 - Lead smelting
 - Welding
7. Does your family use products from other countries such as pottery, health remedies, spices, or food? Yes or Don't Know No

Examples

- Traditional medicines such as Ayurvedic, greta, azarcón, alarcón, alkohl, bali goli, coral, ghasard, liga, pay-loo-ah, and rueda
- Cosmetics such as kohl, surma, and sindor
- Imported or glazed pottery, imported candy, and imported nutritional pills other than vitamins.
- Foods canned or packaged outside the U.S.

Test Immediately

Fax this form to 512-776-7699 or mail to the address below.

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

Questions About Your Child and Tuberculosis (TB)



Child's Name _____ Date of Birth _____

Your Name _____

Today's Date _____

We need your help to find out if your child has been exposed to the disease tuberculosis, also known as TB.

TB is caused by germs. It is usually spread to another person by coughing or sneezing. A person can have TB germs in their body but not have active TB disease. TB can be prevented and treated. Your answers to the questions below will let us know if your child might have been exposed to TB. If your answers show your child might have picked up the TB germs, we will want to give him or her a TB skin test. The skin test is not a vaccination. It will not prevent TB. It will only let us know if your child has the TB germs.

Check the box that matches your answer:	Yes	No	Do Not Know
1. Has your child been tested for TB? If yes, when? Please tell us the date _____			
2. Have you ever been told that your child had a positive TB skin test (TST)? If yes, when? Please tell us the date _____			
3. TB can cause fever that can last days or weeks. It can cause weight loss, a bad cough (lasting over two weeks), or coughing up blood. Has your child been around anyone with any of these problems? Has your child been around anyone sick with TB? Has your child ever had any of these problems or do they have them now?			
4. Was your child born in another part of the world like Mexico or Latin America, the Caribbean, Africa, Eastern Europe, or Asia?			
5. Has your child been to Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe, or Asia for more than 3 weeks? Which country or countries did your child visit? _____			
6. Do you know if your child has spent more than 3 weeks with anyone who: Uses needles for drug use? Has AIDS? Was or is in jail or prison? Has just come to the United States from another country?			

FOR THE PROVIDER:

If the prior test was negative and the answer to #4 is yes, the child does not need a repeat skin test.
If the prior test was negative and occurred at least 8 weeks after the situation described in #3a, 3b, 5, or 6, the child does not need a repeat skin test.
If the prior test was positive, the child does not need a repeat skin test; but a positive answer to #3c would indicate a chest x-ray as soon as possible.

PPD administered Yes ___ No ___

If yes,

Date administered ___/___/___ Date read ___/___/___ PPD response _____ mm

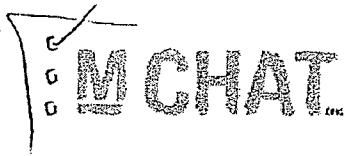
PPD provider _____
Signature _____ Printed Name _____

If chest x-ray done, date and results _____

Provider phone number _____ City _____ County _____

If positive, referral to local/regional health department/specialist? Yes ___ No ___
If yes, name of health dept/specialist _____

Contact your local or regional health department if assistance is needed.



Child's name _____

Date _____

Age _____

Relationship to child _____

M-CHAT-R™ (Modified Checklist for Autism in Toddlers Revised)

Please answer these questions about your child. Keep in mind how your child usually behaves. If you have seen your child do the behavior a few times, but he or she does not usually do it, then please answer no. Please circle yes or no for every question. Thank you very much.

- | | | |
|---|-----|----|
| 1. If you point at something across the room, does your child look at it?
(FOR EXAMPLE, if you point at a toy or an animal, does your child look at the toy or animal?) | Yes | No |
| 2. Have you ever wondered if your child might be deaf? | Yes | No |
| 3. Does your child play pretend or make-believe? (FOR EXAMPLE, pretend to drink from an empty cup, pretend to talk on a phone, or pretend to feed a doll or stuffed animal?) | Yes | No |
| 4. Does your child like climbing on things? (FOR EXAMPLE, furniture, playground equipment, or stairs) | Yes | No |
| 5. Does your child make <u>unusual</u> finger movements near his or her eyes?
(FOR EXAMPLE, does your child wiggle his or her fingers close to his or her eyes?) | Yes | No |
| 6. Does your child point with one finger to ask for something or to get help?
(FOR EXAMPLE, pointing to a snack or toy that is out of reach) | Yes | No |
| 7. Does your child point with one finger to show you something interesting?
(FOR EXAMPLE, pointing to an airplane in the sky or a big truck in the road) | Yes | No |
| 8. Is your child interested in other children? (FOR EXAMPLE, does your child watch other children, smile at them, or go to them?) | Yes | No |
| 9. Does your child show you things by bringing them to you or holding them up for you to see – not to get help, but just to share? (FOR EXAMPLE, showing you a flower, a stuffed animal, or a toy truck) | Yes | No |
| 10. Does your child respond when you call his or her name? (FOR EXAMPLE, does he or she look up, talk or babble, or stop what he or she is doing when you call his or her name?) | Yes | No |
| 11. When you smile at your child, does he or she smile back at you? | Yes | No |
| 12. Does your child get upset by everyday noises? (FOR EXAMPLE, does your child scream or cry to noise such as a vacuum cleaner or loud music?) | Yes | No |
| 13. Does your child walk? | Yes | No |
| 14. Does your child look you in the eye when you are talking to him or her, playing with him or her, or dressing him or her? | Yes | No |
| 15. Does your child try to copy what you do? (FOR EXAMPLE, wave bye-bye, clap, or make a funny noise when you do) | Yes | No |
| 16. If you turn your head to look at something, does your child look around to see what you are looking at? | Yes | No |
| 17. Does your child try to get you to watch him or her? (FOR EXAMPLE, does your child look at you for praise, or say "look" or "watch me"?) | Yes | No |
| 18. Does your child understand when you tell him or her to do something?
(FOR EXAMPLE, if you don't point, can your child understand "put the book on the chair" or "bring me the blanket"?) | Yes | No |
| 19. If something new happens, does your child look at your face to see how you feel about it?
(FOR EXAMPLE, if he or she hears a strange or funny noise, or sees a new toy, will he or she look at your face?) | Yes | No |
| 20. Does your child like movement activities?
(FOR EXAMPLE, being swung or bounced on your knee) | Yes | No |

PEDS RESPONSE FORM

Provider _____

Child's Name _____ Parent's Name _____

Child's Birthday _____ Child's Age _____ Today's Date _____

Please list any concerns about your child's learning, development, and behavior.

Do you have any concerns about how your child talks and makes speech sounds?

Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child understands what you say?

Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child uses his or her hands and fingers to do things?

Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child uses his or her arms and legs?

Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child behaves?

Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child gets along with others?

Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child is learning to do things for himself/herself?

Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child is learning preschool or school skills?

Circle one: No Yes A little COMMENTS:

Please list any other concerns.