NAME:	MEDICAID ID:
DOB:	PRIMARY CARE GIVER:
GENDER: ☐ MALE ☐ FEMALE	PHONE:
DATE OF SERVICE:	INFORMANT:

Texas Health Steps

CHILD HEALTH RECORD

10 YEAR CHECKUP

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:

☐ TB questionnaire*, risk identified: Y ☐ N ☐
**Tuberculin Skin Test if indicated* ☐ TST
(See back for form)

NUTRITION*:
Problems: Y ☐ N ☐
Assessment:

**See Bright Futures Nutrition Book if needed*

IMMUNIZATIONS

☐ Up-to-date
☐ Deferred - Reason:

Given today: ☐ Hep A ☐ Hep B ☐ HPV ☐ IPV
☐ Td/Tdap ☐ Meningococcal* ☐ MMR ☐ MMRV
☐ Pneumococcal* ☐ Varicella ☐ Influenza

**Special populations: See ACIP*

LABORATORY

Tests ordered today:
☐ Dyslipidemia Screening (required once 9 -11 years)
Other:

UNCLOTHED PHYSICAL EXAM

☐ See growth graph

Weight: _____ (_____%) Height: _____ (_____%)
BMI: _____ (_____%) Heart Rate: _____
Blood Pressure: _____/_____ Respiratory Rate: _____
Temperature (optional): _____

☐ Normal (Mark here if all items are WNL)

Abnormal (Mark all that apply and describe):

☐ Appearance	☐ Nose	☐ Lungs
☐ Head	☐ Mouth/throat	☐ GI/abdomen
☐ Skin	☐ Teeth	☐ Extremities
☐ Eyes	☐ Neck	☐ Back
☐ Ears	☐ Heart	☐ Musculoskeletal
		☐ Neurological

Abnormal findings:

Additional:
Tanner Stage
Breasts _____/5 Genitalia _____/5

Audiometric Screening:
R 1000Hz_____ 2000HZ_____ 4000HZ_____
L 1000Hz_____ 2000HZ_____ 4000HZ_____

Visual Acuity Screening:
OD____/____ OS____/____ OU____/____

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

☐ Selected health topics addressed in any of the following areas*

- School Performance
- Physical Activity
- Development and Mental Health
- Nutrition
- Oral Health
- Safety

**See Bright Futures for assistance*

ASSESSMENT

PLAN/REFERRALS

Dental Referral: Y ☐
Other Referral(s)

Return to office:

Signature/title

Signature/title

Texas Health Steps

CHILD HEALTH RECORD

10 YEAR CHECKUP

Name: | Medicaid ID:

Typical Developmentally Appropriate Health Education Topics

10 Year Old Checkup

- Discuss puberty and physical changes/sexuality
- Encourage constructive conflict resolution, demonstrate anger management at home
- Establish consistent limits/rules and consistent consequences
- Establish personal hygiene routine
- Increase difficulty of chores to develop sense of accomplishment and increase self-confidence
- Limit TV/computer time to 2 hours/day
- Provide nutritious meals and snacks; limit sweets/sodas/high-fat foods
- Establish tooth brushing routine twice a day
- During sports wear protective gear at all times
- Encourage outdoor play for 1 hour/day
- Develop a family plan for exiting house in a fire/establish meeting place after exit
- Discuss drug/tobacco/alcohol use and peer pressure
- Get to know child's friends and their parents
- Lock up guns
- Promote use of seat belt and ride in back seat until 12 years old
- Provide home safety for fire/carbon monoxide poisoning
- Provide safe/quality after-school care
- Supervise when near or in water even if child knows how to swim
- Teach self-safety if feeling unsafe at friend's home/car, answer the door/telephone when adult not home, personal body privacy
- Discuss additional help with teacher if there are concerns/bullying
- Discuss school activities and school work
- Provide space/time for homework/personal time

TB QUESTIONNAIRE Place a mark in the appropriate box:	Yes	Do not know	No
Has your child been tested for TB?	☐	☐	☐
If yes, when (date)			
Has your child ever had a positive Tuberculin Skin Test?	☐	☐	☐
If yes, when (date)			
TB can cause fever that lasts for days or weeks, unexplained weight loss, a bad cough (lasting over two weeks), or coughing up blood. As far as you know:			
has your child been around anyone with any of these symptoms or problems?	☐	☐	☐
has your child been around anyone sick with TB?	☐	☐	☐
has your child had any of these symptoms or problems?	☐	☐	☐
Was your child born in Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe, or Asia?	☐	☐	☐
Has your child traveled in the past year to Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe, or Asia for longer than 3 weeks?	☐	☐	☐
If so, specify which country/countries?			
To your knowledge, has your child spent time (longer than 3 weeks) with anyone who is/has been an intravenous (IV) drug user, HIV-infected, in jail or prison, or has recently come to the United States from another country?	☐	☐	☐