Parents as Teachers®

Child Health Record

1 Year

Child's name:

Adjusted age of child in months:

Date of enrollment:

Date health review completed:

Date vision review completed:

Date hearing review completed:

Date of birth:

Gender: Male Female Non-binary
Prefer not to report Unknown

Parent educator:

Prenatal/Postpartum History

Complete this section only if the Prenatal/Postpartum Record was not completed for this child. If the Prenatal/Postpartum Record was completed for this child, skip to the Current Health section.

Prenatal

Did you have any pregnancy-related diagnoses? Unknown No Yes (select all that apply)
Ectopic pregnancy Gestational diabetes In-utero infections Low amniotic fluid Preeclampsia
Placenta previa Rh-negative mother/RH-positive fetus Other (specify):

Neurotoxin exposure during pregnancy: Unknown No Y es (select all that apply)
Alcohol Amphetamines Barbiturates Cocaine/crack Heroin Inhalants Marijuana Mercury
Nicotine/cigarettes/vaping Opioids Pesticides Other (specify):

Labor and Delivery

How many weeks pregnant were you when your child was born?

Birth weight: Pounds Ounces OR kilograms:

Did your child have any medical conditions at birth? This could be anything from jaundice to congenital heart disease.
Unknown No Yes (select all that apply)
Congenital heart disease Jaundice Spina bifida Down syndrome Sickle cell anemia Craniofacial anomalies
Other (specify):

Postpartum

Did your child screen positive at birth for alcohol or drugs? (*optional*) No Alcohol Drugs Both Prefer not to report

Did your child stay in the neonatal intensive care unit (NICU) after they were born? Unknown No Yes
If yes, what was the reason for the stay?
Was the stay 5 days or more? Unknown No Yes

Date(s) of postpartum visits with a healthcare provider (approximate is ok):

Current Health

General Health

Are your child's immunizations up to date? Yes No Unknown

What was the date of your child's last immunization (approximate date is fine)? Unknown

Where does your child get regular checkups? (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 (specify):

(Optional) Length/Height: Inches: OR Centimeters: Weight: Pounds: Ounces: OR Kilograms:

Has your child been diagnosed with any medical conditions? (select all that apply):

None

Cancer	Acquired immunodeficiency syndrome (AIDS)	Asthma
Diabetes	Cerebral palsy	Cystic fibrosis
Epilepsy or seizure disorder	Digestion disorders	Fetal alcohol spectrum disorder (FASD)
Heart disease/defects	Feeding difficulties in early childhood	Human immunodeficiency virus (HIV)
Juvenile arthritis	Genetic disorders	Respiratory allergies
Sickle cell disease	Overweight and obesity	Other (specify):

Has your child been diagnosed with any developmental conditions? (select all that apply):

None

Acquired brain injury and/or neurological disorder	Autism spectrum disorders (ASD)
Developmental disabilities – not otherwise specified	Fragile x syndrome
Learning disability/disabilities	Sensory processing disorder(s)
Attention deficit hyperactivity disorder (ADHD)	Communication, language, and speech disorders
Disruptive behavior disorders	Intellectual disability/disabilities
Motor delay and movement disorder(s)	Other (specify):

Does your child have any allergies? (select all that apply and describe):

None

Environmental:	Food:
Medicines:	Other:

How many hours on average does your child sleep per night? 6 or fewer 7 8 9 10 11 12 13+

Well Child Visit	Received/Missed/Unknown	Well Child Visit	Received/Missed/Unknown	Well Child Visit	Received/Missed/Unknown
5 days	Received Missed Unknown *Approx. date*	9 months	Received Missed Unknown *Approx. date*	2.5 years (30 months)	Received Missed Unknown *Approx. date*
1 month	Received Missed Unknown *Approx. date*	12 months	Received Missed Unknown *Approx. date*	3 years	Received Missed Unknown *Approx. date*
2 months	Received Missed Unknown *Approx. date*	15 months	Received Missed Unknown *Approx. date*	4 years	Received Missed Unknown *Approx. date*
4 months	Received Missed Unknown *Approx. date*	18 months	Received Missed Unknown *Approx. date*	5 years	Received Missed Unknown *Approx. date*
6 months	Received Missed Unknown *Approx. date*	2 years (24 months)	Received Missed Unknown *Approx. date*	6 years	Received Missed Unknown *Approx. date*

List any emergency room visits in the last 12 months, or since last discussed.

Date of ER visit: Notes:
Reason for visit: Injury Illness Poison Other (specify):
Date of ER visit: Notes:
Reason for visit: Injury Illness Poison Other (specify):
Date of ER visit: Notes:
Reason for visit: Injury Illness Poison Other (specify):

Note: *The first Child Health Record should include ER visits in the past year (or since birth, if under 1 year of age)*

Has your child had any hospital stays, not including directly following birth? No Yes
If yes, what was the reason? How long was the stay?

Does your child take any medicine on a daily or weekly basis? No Yes
If yes, what is/are the medicine(s)? *(optional)*

Has your child's health care provider talked to you about any concerns they have about your child's size or weight?
No Yes If yes, what were the concerns?

Has your child been screened for:
Anemia: Unknown No Yes If yes, what were the results? Normal Outside normal ranges Unknown
Lead level: Unknown No Yes If yes, what were the results? Normal Higher than normal Unknown
If results were not normal, what follow-up has taken place?

Nutrition Review

What are you feeding/did you feed your baby? Breast milk Formula Both
If breast milk, for how long? Less than 3 months 3 to 5 months 6 to 9 months More than 9 months
Still in progress Unknown
If breast milk, for how long **exclusively**? Less than 3 months 3 to 5 months 6 to 9 months More than 9 months
Still in progress Unknown Never exclusive

For children up to 12 months *(optional)*

What foods did you first start feeding your child? (select all that apply)
Infant cereal Plain fruits Plain vegetables French fries Meats Dairy products like cheese or yogurt
Grain products like rice or noodles

How often do you add foods such as cereal to your child's bottle? (select one)
Never Once or twice a month Once or twice a week Once a day A few times a day

How often do you use pillows or other items to prop your child's bottle? (select one)
Never Once or twice a month Once or twice a week Once a day A few times a day

For children one year and older *(optional)*

On a typical day, how many times does your child drink juice, fruit/sports drinks, regular pop/soda, sweet tea and/or water with Kool- Aid or sugar? 0 1 2 3 4+

On a typical day, how many times does your child drink diet pop/soda and/or coffee/tea? 0 1 2 3 4+

On a typical day, how many times does your child drink plain water? 0 1 2 3 4+

On a typical day, how many times does your child eat fruit? 0 1 2 3 4+

On a typical day, how many times does your child eat vegetables? 0 1 2 3 4+

Dental Review

Does your child have any teeth yet?

No If no, how often do you clean their gums? Always Sometimes Never

Yes If yes, how often do you brush and floss their teeth? Always Sometimes Never

How often does your child fall asleep with a bottle? (select one) Always Sometimes Never

Does your child have a dentist or dental care provider? No Yes

Has your child had his/her first dental appointment? No Yes

If yes, does your child have cleanings twice a year? No Yes

Safety Review

For all Safety Review items, discuss what the family has done and what else they can do.

For children up to 12 months only

How often does your child sleep in bed with you, another caregiver, or another child? (select one): Always Sometimes Never

Is your child placed on his/her back when they go to sleep? (select one): Always Sometimes Never

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

For all children

Does anyone use tobacco products inside the home? (select one)

Always Sometimes Never

Does your child regularly ride in a car with someone who uses tobacco products? (select one) Always Sometimes Never

Is there is at least one working smoke detector on each floor where you live? Unknown No Yes

Does your child ride in a car seat? Always Sometimes Never If so, does it face: Backwards Forwards

Note: *See the PAT Child Health Record Instructions for information on age ranges for rear- and forward-facing car seats.*

Does your child skate, or ride a bike or scooter? No Yes

If yes, does your child wear a helmet when they skate and/or ride? Always Sometimes Never

Have you been able to childproof your home?

Not yet Partially Fully

Does your family have a plan and supplies in case of an emergency in the home or natural disaster? No Yes

Do you or other caregivers have any health, dental, or safety concerns for your child that we haven't talked about? No Yes

If yes, describe:

Health Review Notes *(optional)*:

Hearing Review

Does your child have a diagnosed hearing impairment? No Yes

Diagnosis:

Treatment plan:

If child has a diagnosed hearing impairment, this section is now complete. Make sure to enter the date Hearing Review is complete. If child does not have a diagnosed hearing impairment, continue with this section.

For children up to 12 months only

Did your child have a newborn hearing screening? No Yes Unknown *(if unknown, help caregiver find out)*

Did your child pass the newborn hearing screening? No Yes Unknown (*If unknown, helps caregiver find out)*

If they didn't pass, was any follow-up recommended? No Yes Unknown (*If unknown, helps caregiver find out)*

Were you able to get your child the recommended follow-up? No Yes *(If no, help caregiver with follow-up)*

For all children

How many ear infections has your child had in the last year? None 1 or 2 3 or 4 5 or 6 7+

If needed, how were the ear infections treated? Antibiotics Ear Tubes Other (specify):

Has your child had a hearing exam by a primary healthcare provider, hearing specialist, or someone else in the last 12 months?

Unknown No Yes If yes, date of latest hearing exam:

Who did the hearing exam? Primary care provider Hearing specialist Other:

Results: Couldn't test Refer Pass Unknown

***Note:** If caregiver answers "yes" to any of the following questions, ask if the child has already been assessed for this. If yes, a resource connection is not necessary, but the parent educator needs to learn about the results of the assessment. If the child has not been assessed, support the parent in following up with the child's healthcare provider or hearing expert.*

Do you or any of your child's other caregivers have concerns about your child's hearing, speech, or language development?	No Yes	If yes, explain:	Child has been assessed for this No Yes If yes, what were the results?

Have you or any of your child's other caregivers noticed regression in your child's hearing, speech, or language development? For example, they could hear or speak more clearly before, and something changed.	No Yes	If yes, explain:	Child has been assessed for this No Yes If yes, what were the results?
Did any of your child's biological parents or siblings have permanent childhood hearing loss?	No Unknown Yes	If yes, explain:	Child has been assessed for this No Yes If yes, what were the results?
Has your child received any medical treatment (including medication) that you were told carried some risk of hearing loss?	No Unknown Yes	If yes, explain:	Child has been assessed for this No Yes If yes, what were the results?

Hearing Screening (*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		Couldn't test Refer Pass Unknown	Couldn't test Refer Pass Unknown
Tympanometry	Parent educator Supervisor Contracted screener Health care provider		Couldn't test Refer Pass Unknown	Couldn't test Refer Pass Unknown
Audiometry	Parent educator Supervisor Contracted screener Health care provider		Couldn't test Refer Pass Unknown	Couldn't test Refer Pass Unknown

Other (specify):	Parent educator Supervisor Contracted screener Health care provider		Couldn't test Refer Pass Unknown	Couldn't test Refer Pass Unknown

Hearing Review Notes *(optional)*:

Vision Review

Does your child have a diagnosed vision impairment? No Yes

Diagnosis:

Treatment plan:

If child has a diagnosed vision impairment, this section is now complete. Make sure to enter the date Vision Review is complete. If child does not have a diagnosed vision impairment, continue with this section.

Has your child had a vision exam by a primary healthcare provider, vision specialist, or someone else in the last 12 months?

Unknown No Yes If yes, date of latest vision exam:

Who did the vision exam? Primary care provider Vision specialist Other:

Results: Couldn't test Refer Pass Unknown

For all children

Note: *If caregiver answers "yes" to any of the following questions, ask if the child has already been assessed for this. If yes, a resource connection is not necessary, but the parent educator needs to learn about the results of the assessment. If the child has not been assessed, support the parent in following up with the child's healthcare provider or vision expert.*

Do you or any of your child's other caregivers have concerns about your child's vision, balance or hand-eye coordination?	No Yes	If yes, explain:	Child has been assessed for this? No Yes If yes, what were the results?

Is there a family history of eye surgeries? No Unknown Yes

Were any biological parent(s) or sibling(s) prescribed corrective lenses (glasses) during childhood?	No Unknown Yes	Child has been assessed for this? No Yes If yes, what were the results?

Are there any biological parent(s)/ sibling(s) who have a history of eye disorder including cataracts, strabismus, amblyopia or refractive error?	No Unknown Yes	Child has been assessed for this? No Yes If yes, what were the results?	
Do your child's eyelids droop or does one tend to close?	No Unknown Yes	Child has been assessed for this? No Yes If yes, what were the results?	
Has your child ever had an eye injury?	No Unknown Yes	Child has been assessed for this? No Yes If yes, what were the results?	
Do either of your child's eyes appear unusual?	No Unknown Yes	If yes, select all that apply: Enlarged pupils Encrusted eyelids Excessive blinking Frequent styes Sensitivity to light Watery eyes Jerky or repetitive eye movements Often rubbing eyes Reddened eyes/eyelids White spots or cloudiness in the pupil Other (explain):	Child has been assessed for all items selected? No Yes If yes, what were the results?
Does your child have any difficulty walking or running due to tripping?	No Unknown Yes	Child has been assessed for this? No Yes If yes, what were the results?	
For 6 months and older only			
Do your child's eyes appear to turn in or out?	No Yes	Child has been assessed for this? No Yes If yes, what were the results?	

Does your child turn or tilt his/her head, place objects close to look at them, or squint while looking at objects?	No Yes	If yes, select all that apply: Turns head to use one eye only Tilts head to use one side often or all the time Places an object close to the eyes to look at it Squints while looking at objects	Child has been assessed for all items selected? No Yes If yes, what were the results?

Vision Screening (*optional*)				
Screening Tool	**Administered By** (select one)	**Date Completed**	**Left Eye** (select one)	**Right Eye** (select one)
LEA Symbols	Parent educator Supervisor Contracted screener Health care provider		Couldn't test Refer Pass Unknown	Couldn't test Refer Pass Unknown
Spot Vision Screener	Parent educator Supervisor Contracted screener Health care provider		Couldn't test Refer Pass Unknown	Couldn't test Refer Pass Unknown
Other (please specify):	Parent educator Supervisor Contracted screener Health care provider		Couldn't test Refer Pass Unknown	Couldn't test Refer Pass Unknown

Vision Review notes *(optional)*:

Reviewed by Dr. Jay Malone, M.D., Ph.D. Washington University in St. Louis, Pediatric Critical Care