|  |  |  |
| --- | --- | --- |
|  | Child’s name: | Date of birth: |
| Adjusted age of child in months: | Gender:  Male  Female  Non-binary  Prefer not to report  Unknown |
| Date of enrollment: | Parent educator: |
| Date of health review completed: | Date hearing review completed: |
| Date vision review completed: |  |

**Prenatal/Postpartum History**

**Child Health Record**

1 year



**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  Yes (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 |
| Did your child have any medical conditions at birth?  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 is ok)?        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  *Approx. date*  Missed  Unknown | | 9 months | Received  *Approx. date*  Missed  Unknown | | | 2.5 years (30 months) | Received  *Approx. date*  Missed  Unknown | |
| 1 month | Received  *Approx. date*  Missed  Unknown | | 12 months | Received  *Approx. date*  Missed  Unknown | | | 3 years | Received  *Approx. date*  Missed  Unknown | |
| 2 months | Received  *Approx. date*  Missed  Unknown | | 15 months | Received  *Approx. date*  Missed  Unknown | | | 4 years | Received  *Approx. date*  Missed  Unknown | |
| 4 months | Received  *Approx. date*  Missed  Unknown | | 18 months | Received  *Approx. date*  Missed  Unknown | | | 5 years | Received  *Approx. date*  Missed  Unknown | |
| 6 months | Received  *Approx. date*  Missed  Unknown | | 2 years  (24 months) | Received  *Approx. date*  Missed  Unknown | | | 6 years | Received  *Approx. date*  Missed  Unknown | |
| 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)* | | | | | | | | | | |

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| --- | --- | --- |
| 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 exclusively | |
| ***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+ |

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| --- |
| **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 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-facing 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 on 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, help caregiver find out)*  If they didn’t pass, was any follow-up recommended?  No  Yes  Unknown *(if unknown, help 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 (specify):  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 the child has, 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 on 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 the child has, 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, amblyopic or refractive error?  © 2020, Parents as Teachers National Center, Inc. ParentsAsTeachers.org | 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 children 6 months and older only***  © 2020, Parents as Teachers National Center, Inc. ParentsAsTeachers.org | | | |
| 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 (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