Parents as Teachers

# Child Health Record

1 year

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

**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)*

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+

## 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<br>☐ Yes | If yes, explain: | Child has been assessed for this ☐ No ☐ Yes<br>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<br>☐ Yes | If yes, explain: | Child has been assessed for this ☐ No ☐ Yes<br>If yes, what were the results? |

| | | | |
|---|---|---|---|
| Did any of your child's biological parents or siblings have permanent childhood hearing loss? | ☐ No<br>☐ Unknown<br>☐ Yes | If yes, explain: | Child has been assessed for this ☐ No ☐ Yes<br>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<br>☐ Unknown<br>☐ Yes | If yes, explain: | Child has been assessed for this ☐ No ☐ Yes<br>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 ☐ Contracted screener<br>☐ Supervisor ☐ Health care provider | | ☐ Couldn't test ☐ Pass<br>☐ Refer ☐ Unknown | ☐ Couldn't test ☐ Pass<br>☐ Refer ☐ Unknown |
| Tympanometry | ☐ Parent educator ☐ Contracted screener<br>☐ Supervisor ☐ Health care provider | | ☐ Couldn't test ☐ Pass<br>☐ Refer ☐ Unknown | ☐ Couldn't test ☐ Pass<br>☐ Refer ☐ Unknown |
| Audiometry | ☐ Parent educator ☐ Contracted screener<br>☐ Supervisor ☐ Health care provider | | ☐ Couldn't test ☐ Pass<br>☐ Refer ☐ Unknown | ☐ Couldn't test ☐ Pass<br>☐ Refer ☐ Unknown |
| Other (specify): | ☐ Parent educator ☐ Contracted screener<br>☐ Supervisor ☐ Health care provider | | ☐ Couldn't test ☐ Pass<br>☐ Refer ☐ Unknown | ☐ Couldn't test ☐ Pass<br>☐ Refer ☐ 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<br>☐ Yes | If yes, explain: | Child has been assessed for this?<br>☐ No ☐ Yes<br>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<br>☐ Unknown<br>☐ Yes | Child has been assessed for this? ☐ No ☐ Yes<br>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? | ☐ No<br>☐ Unknown<br>☐ Yes | Child has been assessed for this? ☐ No ☐ Yes<br>If yes, what were the results? | |
| Do your child's eyelids droop or does one tend to close? | ☐ No<br>☐ Unknown<br>☐ Yes | Child has been assessed for this? ☐ No ☐ Yes<br>If yes, what were the results? | |

| | | | |
|---|---|---|---|
| Has your child ever had an eye injury? | ☐ No<br>☐ Unknown<br>☐ Yes | Child has been assessed for this? ☐ No ☐ Yes<br>If yes, what were the results? | |
| Do either of your child's eyes appear unusual? | ☐ No<br>☐ Unknown<br>☐ Yes | If yes, select all that apply<br>☐ Enlarged pupils ☐ Encrusted eyelids<br>☐ Excessive blinking ☐ Frequent styes<br>☐ Sensitivity to light ☐ Watery eyes<br>☐ Jerky or repetitive eye movements<br>☐ Often rubbing eyes<br>☐ Reddened eyes/eyelids<br>☐ White spots or cloudiness in the pupil<br>☐ Other (explain): | Child has been assessed for all items selected?<br>☐ No ☐ Yes<br>If yes, what were the results? |
| Does your child have any difficulty walking or running due to tripping? | ☐ No<br>☐ Unknown<br>☐ Yes | Child has been assessed for this? ☐ No ☐ Yes<br>If yes, what were the results? | |
| ***For children 6 months and older only*** | | | |
| Do your child's eyes appear to turn in or out? | ☐ No<br>☐ Yes | Child has been assessed for this? ☐ No ☐ Yes<br>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<br>☐ Yes | If yes, select all that apply<br>☐ Turns head to use one eye only<br>☐ Tilts head to use one side often or all the time<br>☐ Places an object close to the eyes to look at it<br>☐ Squints while looking at objects | Child has been assessed for all items selected?<br>☐ No ☐ Yes<br>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<br>☐ Supervisor<br>☐ Contracted screener<br>☐ Health care provider | | ☐ Couldn't test<br>☐ Refer<br>☐ Pass<br>☐ Unknown | ☐ Couldn't test<br>☐ Refer<br>☐ Pass<br>☐ Unknown |
| Spot Vision Screener | ☐ Parent educator<br>☐ Supervisor<br>☐ Contracted screener<br>☐ Health care provider | | ☐ Couldn't test<br>☐ Refer<br>☐ Pass<br>☐ Unknown | ☐ Couldn't test<br>☐ Refer<br>☐ Pass<br>☐ Unknown |
| Other (specify): | ☐ Parent educator<br>☐ Supervisor<br>☐ Contracted screener<br>☐ Health care provider | | ☐ Couldn't test<br>☐ Refer<br>☐ Pass<br>☐ Unknown | ☐ Couldn't test<br>☐ Refer<br>☐ Pass<br>☐ Unknown |

Vision Review notes *(optional)*:

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