



Parents as Teachers™

Child Health Record

Child's name: _____ Due date/birth date: _____

Gender: _____ Form completion date: _____

Adjusted age of child in months (for children up to 3 years of age who were born preterm): _____

Is this the first Child Health Record? Yes No

Pregnancy history

Prenatal

Dates of prenatal care visits to obstetrician: _____

Mother uses/used folic acid supplements during pregnancy?

Yes No

Frequency of folic acid use (select one):

2 or fewer times per week 3 to 4 times per week
 5 or more times per week

Mother uses/used vitamin supplements during pregnancy?

Yes No

Frequency of vitamin use (select one):

2 or fewer times per week 3 to 4 times per week
 5 or more times per week

Baby exposed to neurotoxins before birth? (check all that apply):

Alcohol Amphetamines Barbituates Caffeine Cocaine/crack Inhalants Marijuana
 Mercury Nicotine/cigarettes Opioids/heroin Pesticides
 Other (please specify): _____

Mother diagnosed with (check all that apply):

Ectopic pregnancy Gestational diabetes Low amniotic fluid Preeclampsia Placenta previa
 Other (please specify): _____

High-risk pregnancy?

Yes No

Did this pregnancy result in (check one):

Miscarriage Stillborn birth Live birth

Pregnancy notes:

Labor and delivery

Type of delivery: Caesarean section Vaginal Difficulty? Difficulty during labor Difficulty during delivery

Birth weight: _____ pounds _____ ounces Weeks of gestation (when baby was born): _____

Special conditions at birth (check all that apply):

Congenital heart disease Jaundice Spina bifida Down syndrome Sickle cell anemia

Other (please specify): _____

Postpartum

Only need to answer if child is 12 months or younger.

Child was breastfed? Yes No

If yes: How long was the child breastfed? Less than 3 months

3 to 5 months 6 to 9 months

More than 9 months Still in progress

Where was breastfeeding initiated?

In the hospital In the home

Is child exclusively breastfed (during the first 6 months)?

Yes No

Date(s) of postpartum visit(s):

Health review

Medical visits and conditions					
Dates of well-child visits					
5 days		9 months		2.5 years (30 months)	
1 month		12 months		3 years	
2 months		15 months		4 years	
4 months		18 months		5 years	
6 months		2 years (24 months)			



Immunizations up to date? Yes No

Date last received immunizations: _____

If not up to date, please specify why not: _____

Primary location for child's regular medical checkups and sick care (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
 Other (please specify): _____

Child has had any illness with high fever (104°F or more) longer than two days. Yes No

Medical conditions (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Acquired immunodeficiency syndrome (AIDS) | <input type="checkbox"/> Hearing impairment |
| <input type="checkbox"/> Asthma and respiratory allergies | <input type="checkbox"/> Heart disease/defects |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Human immunodeficiency virus (HIV) |
| <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> Juvenile arthritis |
| <input type="checkbox"/> Cystic fibrosis | <input type="checkbox"/> Overweight and obesity |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Prematurity and low birth weight |
| <input type="checkbox"/> Digestion disorders | <input type="checkbox"/> Sickle cell disease |
| <input type="checkbox"/> Emotional/mental health disorders | <input type="checkbox"/> Spina bifida/neural tube defects |
| <input type="checkbox"/> Feeding difficulties in early childhood | <input type="checkbox"/> Visual impairment |
| <input type="checkbox"/> Fetal alcohol spectrum disorder (FASD) | <input type="checkbox"/> Other (please specify): _____ |
| <input type="checkbox"/> Genetic disorders | |

Developmental conditions (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Acquired brain injury and selected neurological disorders | <input type="checkbox"/> Disruptive behavior disorders |
| <input type="checkbox"/> Attention deficit hyperactivity disorder (ADHD) | <input type="checkbox"/> Learning disabilities |
| <input type="checkbox"/> Autism spectrum disorders (ASD) | <input type="checkbox"/> Motor delay and movement disorders |
| <input type="checkbox"/> Communication, language, and speech disorders | <input type="checkbox"/> Sensory processing disorder |
| <input type="checkbox"/> Developmental disabilities – not otherwise specified | <input type="checkbox"/> Other (please specify): _____ |

Allergies (check all that apply):

- Environmental
 Food
 Medicines
 Other (please specify): _____

Child's health insurance (check all that apply):

- No insurance coverage
 Tri-care
 Unknown
 Title XIX (Medicaid/Title XXI – state children's insurance program)
 Private or other
 Did not report

<p>Emergency room visits</p> <p>Date of visit: _____</p> <p>Reason for visit: <input type="checkbox"/> Injury <input type="checkbox"/> Illness <input type="checkbox"/> Poison <input type="checkbox"/> Other (please specify): _____</p> <p>Referred by health care professional: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Date of visit: _____</p> <p>Reason for visit: <input type="checkbox"/> Injury <input type="checkbox"/> Illness <input type="checkbox"/> Poison <input type="checkbox"/> Other (please specify): _____</p> <p>Referred by health care professional: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Date of visit: _____</p> <p>Reason for visit: <input type="checkbox"/> Injury <input type="checkbox"/> Illness <input type="checkbox"/> Poison <input type="checkbox"/> Other (please specify): _____</p> <p>Referred by health care professional: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Date of visit: _____</p> <p>Reason for visit: <input type="checkbox"/> Injury <input type="checkbox"/> Illness <input type="checkbox"/> Poison <input type="checkbox"/> Other (please specify): _____</p> <p>Referred by health care professional: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Medicines and supplements taken regularly (check all that apply):</p> <p><input type="checkbox"/> Over-the-counter drugs <input type="checkbox"/> Ear drops <input type="checkbox"/> Vitamin supplements <input type="checkbox"/> Antibiotics <input type="checkbox"/> Eye ointment <input type="checkbox"/> Asthma inhalers <input type="checkbox"/> Other (please specify): _____</p>	
<p>According to the health care provider, are child's size and weight OK? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, please specify concerns about child's size or weight: _____</p>	
<p>Child has been screened for anemia? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please specify results of anemia screening: _____</p>	
<p>Child has been screened for lead levels? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please specify results of lead screening: _____</p>	

Dental review

Brushing teeth, flossing, and/or cleaning gums is part of the child's daily routine? (select one):

Always Sometimes Never

Child falls asleep with a bottle? (select one): Always Sometimes Never

Parent has concerns about the child's teeth or gums? Yes No

If yes, please specify concerns about teeth or gums: _____

Child has a source of dental care? Yes No

Child has regular dentist appointments? Yes No

Child had his/her first dental appointment? Yes No

According to the American Academy of Pediatric Dentistry, a dental home enhances the dental professional's ability to assist children and their parents in the quest for optimum oral health care, beginning with the age 1 dental visit for successful preventive care and treatment as part of an overall oral health care foundation.

Safety review

For children up to 12 months

Does child bed-share? (select one): Always Sometimes Never

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

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

For all children

Is child exposed to secondhand smoke? (select one): Always Sometimes Never

Notes regarding secondhand smoke exposure: _____

Safety review (continued)

There is at least one working smoke detector on each floor where the family resides.

Child rides in an approved car seat according to state law.

General guidelines: Rear-facing safety seat in the back seat from birth to age 2 and forward-facing safety seat in the back seat until at least age 5.

If child is involved in biking, skating, riding a scooter, or similar device, a helmet is used.

Home is childproofed (for example, to prevent accidental poisoning, choking, and other injuries).

Family has a plan and supplies in case of an emergency in the home or natural disaster.

Date Health Review completed: _____

Hearing review

Hearing review

For children up to 12 months (select one response option):

Child had a newborn hearing screening?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Parent/guardian is unsure
--	------------------------------	-----------------------------	--

If parent/guardian indicates child did not have a newborn hearing screening or is unsure, the parent educator should help the parent/guardian follow up.

If yes: Newborn hearing screening record obtained?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Newborn hearing screening results:	<input type="checkbox"/> Pass	<input type="checkbox"/> Fail	<input type="checkbox"/> Unknown
Newborn hearing screening follow-up recommended?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Newborn hearing screening follow-up obtained?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A

Additional information: _____

For all children

Child has had ear infections? Yes No

If yes, number of ear infections:
 1 or 2 times 3 or 4 times 5 or 6 times
 7 or more times

What were the treatments?
 Antibiotics Ear tubes
 Other (please specify): _____

Child's hearing has been checked by a health care provider in the last 12 months: Yes No

Results of the hearing check: _____

Child has had an audiology exam in the last 12 months:
 Yes No

Who did the audiology exam?

Date of the latest audiology exam: _____

Documentation of the audiology exam obtained?
 Yes No

Results of the audiology exam: _____

Hearing review (continued)

Answer questions 1 through 8 for children under 2 years; answer questions 6 through 12 for children 2 years and older.

1. Reacts to sudden loud noises.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Turns head toward interesting sounds or when name is called.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Coos to himself and makes noise when he is alone.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Uses voice to get attention.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Tries to imitate you if you make his own sounds.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Seems to hear you if you talk in a whisper.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Seems to speak as well as other children the same age.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Has a family history of hearing problems.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Seems to have difficulty hearing.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10. Needs the television louder than other members of the family.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11. Seems to favor one ear over the other.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
12. Makes you talk loudly or repeat frequently.	<input type="checkbox"/> Yes	<input type="checkbox"/> No

A no answer for items 1 through 7 indicates the need for discussion and follow-up. A yes answer for items 8 through 12 indicates the need for discussion and follow-up.

Hearing screening (optional)				
Screening tool:	Administered by (select one):	Date completed:	Left ear (select one):	Right ear (select one):
OAE	<input type="checkbox"/> Parent educator <input type="checkbox"/> Supervisor <input type="checkbox"/> Contracted screener <input type="checkbox"/> Health care provider		<input type="checkbox"/> Can't test <input type="checkbox"/> Refer <input type="checkbox"/> Pass	<input type="checkbox"/> Can't test <input type="checkbox"/> Refer <input type="checkbox"/> Pass
Tympanometry	<input type="checkbox"/> Parent educator <input type="checkbox"/> Supervisor <input type="checkbox"/> Contracted screener <input type="checkbox"/> Health care provider		<input type="checkbox"/> Can't test <input type="checkbox"/> Refer <input type="checkbox"/> Pass	<input type="checkbox"/> Can't test <input type="checkbox"/> Refer <input type="checkbox"/> Pass
Audiometry	<input type="checkbox"/> Parent educator <input type="checkbox"/> Supervisor <input type="checkbox"/> Contracted screener <input type="checkbox"/> Health care provider		<input type="checkbox"/> Can't test <input type="checkbox"/> Refer <input type="checkbox"/> Pass	<input type="checkbox"/> Can't test <input type="checkbox"/> Refer <input type="checkbox"/> Pass
<p><i>Note: OAE, tympanometry, and/or audiometry can be beneficial but are not required to meet the PAT Essential Requirements.</i></p>				
<p>Comments/suggestions:</p>				

Date Hearing Review completed: _____

Vision review

Vision review

Child had an eye exam by a pediatrician, eye doctor, or other qualified professional in the last 12 months? Yes No

Date of the latest eye exam: _____ Who did the eye exam? _____

Results of the eye exam: _____

Documentation of the eye exam obtained? Yes No

The child:

1. Has eyes crossed – turning in or out – at any time, or eyes that do not appear straight, especially when child is tired.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Has reddened eyes or eyelids.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Has encrusted eyelids.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Has frequent styes (pimples on the eyelid).	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Has eyes that appear to move more than other people's eyes do.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Has eyelids that droop.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Has white spots or cloudiness covering some or all of the center of the eye.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Complains of burning, itching, or pain in the eyes.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Stares at bright lights frequently or repeatedly flicks objects in front of face.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10. Is bothered by light more than you are.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11. Exhibits a pupil (the dark center of the eye) that seems larger or smaller than the pupil in other children's eyes.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
12. Complains of headache or nausea.	<input type="checkbox"/> Yes	<input type="checkbox"/> No

A yes answer for any item 1 through 12 indicates the need for discussion and follow-up.

Vision review (continued)

13. Has watery eyes.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
14. Complains of tired eyes; rubs eyes often.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
15. Moves the head forward or backward while looking at distant objects.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
16. Turns the head to use one eye only (closes or covers one eye).	<input type="checkbox"/> Yes	<input type="checkbox"/> No
17. Tilts the head to one side often or all the time.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
18. Places an object close to the eyes to look at it.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
19. Squints while looking at objects.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
20. Blinks more than you do.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
21. Has difficulty walking or running; trips over objects more often than others do.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
22. Is unable to see distant objects.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
23. Has a family history of lazy eye or vision problems.	<input type="checkbox"/> Yes	<input type="checkbox"/> No

A yes answer for three or more items on 13 through 23 indicates the need for discussion and follow-up.

Functional vision

Who administered the screening? (select one):

Parent educator
 Supervisor
 Contracted screener
 Health care provider

Date completed: _____

	Left eye (select one):	Right eye (select one):
Blink reflex	<input type="checkbox"/> Present <input type="checkbox"/> Absent	<input type="checkbox"/> Present <input type="checkbox"/> Absent
Pupillary response	<input type="checkbox"/> Present <input type="checkbox"/> Absent	<input type="checkbox"/> Present <input type="checkbox"/> Absent
Corneal light reflex	<input type="checkbox"/> Present <input type="checkbox"/> Absent	<input type="checkbox"/> Present <input type="checkbox"/> Absent
Tracking	<input type="checkbox"/> Present <input type="checkbox"/> Absent	<input type="checkbox"/> Present <input type="checkbox"/> Absent
Reaching	<input type="checkbox"/> Present <input type="checkbox"/> Absent	<input type="checkbox"/> Present <input type="checkbox"/> Absent
Comments/suggestions:		
Other screenings (such as acuity screening for children over 2.5 years of age): _____		

Date Vision Review completed: _____