Child Health Record

Child's Name: Child First Name Child Last Name
Family Name: Family Name
Guardians: Guardian First Name Guardian Last Name
Due date:
Age: 0 (0 month)
DOB: 8/1/2023
Gender: F

Screener	Home Visitor
Is this the first Child Health Record?	No

Date Health Review Completed:	8/1/2023
Date Hearing Review Completed:	8/1/2023
Date Vision Review Completed:	8/1/2023

Prenatal/Postpartum History

Prenatal

Did you have any pregnancy-related diagnoses?
Unknown
Mother diagnosed with:
Other (Please specify):
Neurotoxin exposure during pregnancy
Unknown
Baby exposed to neurotoxins before birth?
Other (Please specify):
Pregnancy notes:

Labor and delivery

How many weeks pregnant were you when your child was born? 0
Birth Weight: 0 Lbs 0 Oz

Did your child have any medical conditions at birth?
Unknown
If yes, Select all that apply
Other (Please specify):

Postpartum

Did your child screen positive at birth for alcohol or drugs? *(optional)*	Prefer not to report
Did your child stay in the neonatal intensive care unit (NICU) after they were born?	Unknown
Date(s) of postpartum visit(s):	

Current Health

Date Health Review Completed: 8/1/2023

Are your child's immunizations up to date? Unknown

General Health

Where does your child get regular checkups?

Date	Source of medical care

(Optional) Length/Height	Centimeters	
(Optional) Weight	Lbs oz	or Kilograms

Has your child been diagnosed with any medical conditions?

Other (Please specify):

Has your child been diagnosed with any developmental conditions?

Other (Please specify):

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

Other (Please specify):

Allergy description:

How many hours on average does your child sleep per night?

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)	6 years

Emergency room visits:

Date of visit	Reason	Referred by health care professional

Has your child had any hospital stays, not including directly following birth?	No
Does your child take any medicine on a daily or weekly basis?	No
Has your child's health care provider talked to you about any concerns they have about your child's size or weight?	No
Child has been screened for anemia?	No
Child has been screened for lead levels?	No

Nutrition Review

What are you feeding/did you feed your baby?	
If breast milk, for how long?	Unknown
If breast milk, for how long exclusively?	Unknown

For children up to 12 months (optional)
What foods did you first start feeding your child?
How often do you add foods such as cereal to your child's bottle?
How often do you use pillows or other items to prop your child's bottle?

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?
On a typical day, how many times does your child drink diet pop/soda and/or coffee/tea?
On a typical day, how many times does your child drink plain water?
On a typical day, how many times does your child eat fruit?
On a typical day, how many times does your child eat vegetables?

Dental review

Does your child have any teeth yet?
Yes
If yes, how often do you brush and floss their teeth?
Always
How often does your child fall asleep with a bottle?
Never
Does your child have a dentist or dental care provider?
Yes
Has your child had his/her first dental appointment?
Yes
Does your child have a dentist or dental care provider?
Yes

Safety review

For children up to 12 months
Safe sleep

Date	Bed-Share	Placed on back	Soft bedding

For all children
Does anyone use tobacco products inside the home?
Does your child regularly ride in a car with someone who uses tobacco products?
Notes regarding secondhand smoke exposure:
Is there at least one working smoke detector on each floor where you live?
Does your child ride in a car seat?
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
Have you been able to childproof your home?
Does your family have a plan and supplies in case of an emergency in the home or natural disaster?
No
Do you or other caregivers have any health, dental, or safety concerns for your child that we haven't talked about?

Hearing review

Date Hearing Review Completed: 8/1/2023

Does your child have a diagnosed hearing impairment?
No

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? *(if unknown, help caregiver find out)*

Additional information

For all children

How many ear infections has your child had in the last year?

If needed, how were the ear infections treated?

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

Do you or any of your child's other caregivers have concerns about your child's hearing, speech, or language development?

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.

Did any of your child's biological parents or siblings have permanent childhood hearing loss?

Has your child received any medical treatment (including medication) that you were told carried some risk of hearing loss?

Hearing Screening: (optional)

Tool	Administered by	Date completed	Left ear	Right ear

Hearing Review Notes (optional):

Vision review

Date Vision Review Completed: 8/1/2023

Vision review

Does your child have a diagnosed vision impairment?

No

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?

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?

Is there a family history of eye surgeries?

Were any biological parent(s) or sibling(s) prescribed corrective lenses (glasses) during childhood?

Are there any biological parent(s)/ sibling(s) who have a history of eye disorder including cataracts, strabismus, amblyopic or refractive error?

Do your child's eyelids droop or does one tend to close?

Has your child ever had an eye injury?

Do either of your child's eyes appear unusual?

Unknown

Does your child have any difficulty walking or running due to tripping?

For children 6 months and older only

Do your child's eyes appear to turn in or out?

Does your child turn or tilt his/her head, place objects close to look at them, or squint while looking at objects?

Unknown

Vision Screening (optional)

Screening Tool

Who administered the screening?

Date completed:
Left Eye (select one)
Right Eye (select one)
Vision Review notes (optional):

Comments:

Signature **Date**