

Child's name: \_\_\_\_\_

Allergies: \_\_\_\_\_

For the form below, mark with an "X" all that applies.

**Lead Screening Assessment:**

Does the child:

Yes	No	
___	___	Live in or regularly visit a house with peeling or chipping paint built before 1960? (Includes daycare centers, preschool, baby-sitter, relatives, etc.)
___	___	Live in or regularly visit a house built before 1960 with recent, ongoing, or planned renovation or remodeling?
___	___	Live in a house with plumbing made of lead pipes or copper with lead solder joints?
___	___	Take any home or folk remedies, which may contain lead, eat or drink from pottery or dishes, which are homemade or made in another country that may contain lead?
___	___	Have a brother, sister, housemate or playmate being followed or treated for lead poisoning? (blood level 15 mcg/DL or more)
___	___	Live with or have frequent contact with any adult whose job or hobby involves exposure to lead?
___	___	Live near a heavily traveled major highway, an active lead smelter, battery recycling plant, or other industry where dust and soil may be contaminated with lead?

**Tuberculosis Risk Assessment: Is or has the child:**

Yes	No	
___	___	In close contact with people with infectious Tuberculosis (IE: family members, friends, day care)?
___	___	Born, lived in or visited outside the United States within the last year and does not have a documented negative Tb test?
___	___	Living in a residential facility (IE: nursing home, shelter, drug treatment center, or correctional facility)?
___	___	Had Tb infection within past 2 years?
___	___	Had chest x-ray findings to check for Tb?
___	___	Recently received the BCG vaccine? (This vaccine is not widely used in the U.S. It is used in countries where Tb is common)

**Social History:** \_\_\_ No change from last visit

With whom does the child live with most of the time:

\_\_\_ Both parents in the same household

\_\_\_ Father \_\_\_ Stepmother \_\_\_ Stepfather \_\_\_ Mother \_\_\_ Guardian

\_\_\_ Brother(s)/Sister(s)

**Primary Drinking Water:**

\_\_\_ Well

\_\_\_ City/Municipal

\_\_\_ Contains Fluoride

**Family Health History:** Check all that apply to the *immediate* family (parents, aunts/uncles, siblings, grandparents)

\_\_\_ No change from last visit

\_\_\_ Diabetes \_\_\_ Heart Disease \_\_\_ Obesity \_\_\_ High blood pressure \_\_\_ Elevated cholesterol \_\_\_ Cancer

\_\_\_ Kidney disease \_\_\_ Blood disorder \_\_\_ Tuberculosis \_\_\_ Asthma \_\_\_ Allergies \_\_\_ Seizures

\_\_\_ Thyroid problems \_\_\_ Mental illness \_\_\_ Drug use \_\_\_ Alcohol use \_\_\_ Tobacco use \_\_\_ Suicide

\_\_\_ Eating disorders \_\_\_ Mental retardation \_\_\_ Other

**Child Health History:** \_\_\_ No change from last visit

Any problems since the birth of your child? Please list below:

**Dental History:** \_\_\_ Seen dentist in last six months \_\_\_ Problems with gums

\_\_\_ Aware of brushing teeth at least two times a day \_\_\_ Problems with cavities

**Hospitalizations:** When

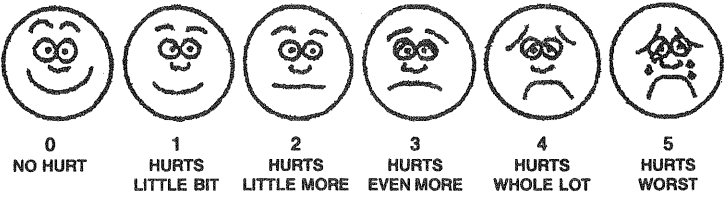
\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please circle the face that matches the pain your child is having today.



Do you have any concerns regarding domestic violence or child abuse/neglect?    YES    NO

**Immunizations:**

Have any been started? If yes, please list below:

\_\_\_ Done here

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_ Records Requested

**Current Medications:** List name(s) of medication(s) the child is currently taking. Include vitamins, supplements, herbs, and oxygen:

**Have you ever had to avoid health care for your child due to any of the following:**

\_\_\_ Transportation

\_\_\_ Money

\_\_\_ Inconvenient