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

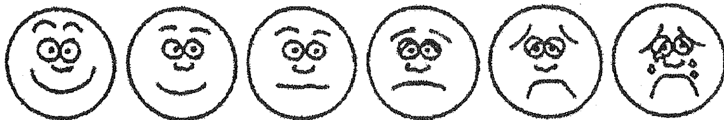
Hospitalizations: When

____

____

____

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