

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.



0 NO HURT 1 HURTS LITTLE BIT 2 HURTS LITTLE MORE 3 HURTS EVEN MORE 4 HURTS WHOLE LOT 5 HURTS WORST

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

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

- Transportation
- Money
- Inconvenient

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