

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:

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

Immunizations:

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

____ Done here

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

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