

MARYLAND HEALTHY KIDS PROGRAM

Preventive Screen Questionnaire

Lead Risk Assessment:

(every well child visit from 6 months up to 6 years)

	<i>Date</i>	<i>Date</i>	<i>Date</i>	<i>Date</i>	<i>Date</i>	<i>Date</i>	<i>Date</i>
	_____	_____	_____	_____	_____	_____	_____
1. Has your child ever lived or stayed in a house or apartment that is more than built before 1978? (includes day care center, preschool home, home of babysitter or relative)	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
2. Is anyone in the home being treated or followed for lead poisoning?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
3. Are there any current renovations or peeling paint in a home that your child regularly visits?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
4. Does your child lick, eat or chew things that are not food? (paint chips, dirt, railings, poles, furniture, old toys, etc.)	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
5. Is there any family member who is currently working in an occupation or hobby where lead exposure could occur? (auto mechanic, ceramics, commercial painter, etc.)	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N

(A "yes" or "don't know" response to any question indicates a positive risk)

	<i>Date</i>	<i>Date</i>	<i>Date</i>	<i>Date</i>	<i>Date</i>	<i>Date</i>	<i>Date</i>
	_____	_____	_____	_____	_____	_____	_____
Tuberculosis Risk Assessment:							
<i>(Starting at 1 year of age and annually thereafter)</i>							
1. Has your child been exposed to anyone with a case of TB?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
2. Was your child, or a household member, born in an area where TB is common (e.g., Africa, Asia, Latin America, and the Caribbean)?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
3. Has your child, or a household member, lived more than a year in an area where TB is common?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
4. Does your child have daily contact with adults at high risk for TB (e.g., those who are HIV infected, homeless, incarcerated, and/or illicit drug users)?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
5. Does your child have HIV infection?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N

(A "yes" response to any question indicates a positive risk)

Patient Name: _____ Birth Date: _____

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Preventive Screen Questionnaire

Heart Disease/Cholesterol Risk Assessment:

(2 years through 20 years)

	<i>Date</i>	<i>Date</i>	<i>Date</i>	<i>Date</i>	<i>Date</i>	<i>Date</i>
1. Is there a family history of parents/grandparents under 55 years of age with a heart attack, heart surgery, angina or sudden cardiac death?	_____	_____	_____	_____	_____	_____
	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
2. Has the child's mother or father been diagnosed with high cholesterol? (240 mg/dL or higher)	_____	_____	_____	_____	_____	_____
	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
<i>(A "yes" response to <u>either</u> question 1 or 2 indicates a positive risk.)</i>						
3. Is the child/adolescent overweight?	_____	_____	_____	_____	_____	_____
	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
4. And is there also a personal history of:						
Smoking?	_____	_____	_____	_____	_____	_____
	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Lack of physical activity?	_____	_____	_____	_____	_____	_____
	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
High blood pressure?	_____	_____	_____	_____	_____	_____
	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
High cholesterol?	_____	_____	_____	_____	_____	_____
	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Diabetes mellitus?	_____	_____	_____	_____	_____	_____
	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N

(A "yes" response to both questions 3 and 4 indicates a positive risk)

Date Date Date Date Date Date

STD/HIV Risk Assessment:

(12 years through 20 years)

	<i>Date</i>	<i>Date</i>	<i>Date</i>	<i>Date</i>	<i>Date</i>	<i>Date</i>
1. Have you had a blood transfusion or are you a Hemophiliac?	_____	_____	_____	_____	_____	_____
	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
2. Have you ever been sexually molested or physically attacked?	_____	_____	_____	_____	_____	_____
	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
3. Have you ever been diagnosed with any sexually transmitted diseases?	_____	_____	_____	_____	_____	_____
	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
4. Any history of IV drug use by you, your sex partner, or your birth mother during pregnancy?	_____	_____	_____	_____	_____	_____
	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
5. If sexually active, have you had unprotected sex, with opposite/same sex?	_____	_____	_____	_____	_____	_____
	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
6. If sexually active, have you had more than one partner?	_____	_____	_____	_____	_____	_____
	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
7. Any body tattoos or body piercing of ears, navel, etc, including any performed by friends?	_____	_____	_____	_____	_____	_____
	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N

(A "yes" response to any question indicates a positive risk)

Patient Name: _____ Birth Date: _____