Place Patient Label Here

PREVENTIVE MEDICINE SCREENING QUESTIONNAIRE		
Lead Risk Questionnaire (ages 6 months to 6 years)	YES	NO
1. Does your child live in or regularly visit a house with peeling, flaking, chipping paint built before 1978? Including but not limited to home, daycare, or relative?		
2. Does your child live in or regularly visit a house built before 1978, with recent, ongoing or planned renovations?		
3. Does your child have a brother or sister, a housemate, or playmate being followed or treated for lead poisoning?		
4. Does your child eat or lick non-edible objects, such as dirt, wood, railings?		
5. Does your child live with someone whose job or hobby involves exposure to lead?		
6. Does your child live near an active lead smelter, battery recycling plant, or other industry likely to release lead?		
Tuberculosis Risk Assessment (ages 1 month through 21 years)		
1. Was your child born in a high risk country ? (countries other than U.S., Canada, Australia, New Zealand or Western and North European countries) If yes, what country and year.		
2. Has your child traveled (had contact with resident populations) to a high-risk country for more than 1 week?		
3. Has your child had a family member or contact with tuberculosis disease?		
4. Has your child had a family member with a positive tuberculin skin test result (PPD)?		
Heart Disease/Cholesterol Risk Assessment (ages 2 through 21 years)		
1. Is there family history of Parent/Grandparent under the age of 55 who underwent a study of the heart blood vessels and were found to have hardening of the arteries? This includes Parent/Grandparent that have undergone balloon heart procedure of bypass surgery.		
2. Is there a family history of Parent/Grandparent under the age of 55 who have suffered a heart attack, a stroke, or have angina, or blood vessel disease?		
3. Does either Parent have high blood cholesterol (240 mg/dl or higher)?		
4. Does the patient (teen/child) have a history of:		
Smoking?		
Lack of physical activity?		
High blood pressure?		
High cholesterol?		
Obesity/overweight?		
Diabetes?		
Mental Health Screening		
1. Have you or your child been the victim of violence or abuse (hit, slapped, hurt)?		
2. Is there a recent stress on the family or child such as birth of a child, moving, divorce or separation, death of a close relative?		

STD/HIV Risk Assessment (ages 12 through 20 years)		
1. Has the patient had a blood transfusion or is he/she currently diagnosed with Hemophilia?		
2. Has the patient ever been diagnosed with any sexually transmitted diseases? (gonorrhea, syphilis, venereal warts, chlamydia, herpes)		
3. Has the patient ever been sexually molested or physically attacked?		
4. Any history of IV drug use by patient, patient's sex partner or patient's birth mother during pregnancy?		
5. If sexually active, has the patient had unprotected sex with opposite/same sex partner?		
6. If sexually active, has the patient had more than one sex partner?		
7. Does the patient have any tattoos or body piercings including any performed by friends?		