

COMPLETE BOTH SIDES OF THIS SHEET, PLEASE.

Patient's Name: _____

Date: _____

Completed by: _____

Relationship to patient: _____

HEALTH ASSESSMENT SCREENING QUESTIONNAIRE FOR 0-5 MONTHS

Social/Environment

Home occupants (if multiple homes, list separately)

Pets _____ Please check if changes in family setting since last exam _____

Yes ___ No ___ Is your child exposed to tobacco products?

Yes ___ No ___ Does either parent smoke?

Hearing: Routine screening was done at birth and will be done yearly starting at age 4, unless done elsewhere.

Yes ___ No ___ Is there any family history of hearing impairment?

Yes ___ No ___ Any concern today regarding your child's hearing?

Vision: Routine screening will be done yearly starting at age 4, unless done elsewhere.

Yes ___ No ___ Any family history of eye problems other than near or farsightedness?

Yes ___ No ___ Any concerns today regarding your child's vision?

Immunizations:

Yes ___ No ___ Has your child ever had a serious reaction to prior immunizations?

Yes ___ No ___ Are there any immunocompromised people (ex: on chemotherapy, HIV positive) around your child?

Yes ___ No ___ Has your child had Chicken Pox?

Fluoride: The need for any supplementation depends on the age of the child, the level of fluoride concentration in your water supply, and the amount of water in your child's diet. Municipal water supplies in this area are fluoridated. Well water in North Georgia and most bottled waters are not.

Yes ___ No ___ Is your water source fluoridated?

Lead

Yes ___ No ___ Does your child live in or regularly visit a house or child care facility built before 1950?

Yes ___ No ___ Does your child live in or regularly visit a house or child care facility built before 1978 that is being or has recently been remodeled or renovated (within the last 6 months)?

Yes ___ No ___ Does your child have a sibling or playmate who has or did have lead poisoning?

Yes ___ No ___ Does your child live with anyone that works at a job where lead may be found or has a hobby that uses lead?

Yes ___ No ___ Does your child chew on or eat non-food items like paint chips or dirt?

PLEASE TURN PAGE OVER

Tuberculosis screening: While the vast majority of children in the U.S. have little or no risk of becoming infected with tuberculosis, a few children may be at increased risk and should have a tuberculin skin test done. Please answer the following questions to help us determine your child's risk factors.

Yes___No___ Is the child in close contact to a person sick with active TB disease?

Yes___No___ Does the child have or is at risk to have HIV?

Yes___No___ Was the child or the child's parents born outside of the United States?

Yes___No___ Is the child exposed to a person in jail or a person who has been in jail in the past five years?

Yes___No___ Is the child exposed to a person who has HIV, who is homeless or who lives in a nursing home or another group home?

Yes___No___ Is the child exposed to drug users or migrant farm workers?

Yes___No___ Does the child have a health problem that lowers the immune system?

Yes___No___ Does the child live in a community that has a high risk for TB?

Yes___No___ Has the child traveled to or had a visitor from any foreign country since the last visit?

Yes___No___ Does the child have any symptoms of TB (cough, fever, night sweats, loss of appetite, weight loss, or fatigue) or any abnormal chest x-ray?

Vitamin D

Yes___No___ Is your child exclusively breast fed?
(May need Vitamin D supplement)

11/2007
0-5 months

Reviewed: _____