Administered by: ______________________ Date: ___/___/___

Childhood Lead Risk Questionnaire

For assessing lead exposures in children.

Instructions: 1. Ask the child's parent or guardian the following questions and mark their responses.

2. If guardian answers **YES** or Don't Know (**D/K**) to any question, test the child for lead as soon as possible.

Child's Name: ______________________

Date of Birth: ___/___/___ **Age:** ____ years

Gender (circle one): **MALE** **FEMALE**

Provider's Name: ______________________

Please answer **YES,** Don't Know (**D/K**) or **NO** to the following questions:

	YES	D/K	NO
1. Does your child live in or visit homes, day care centers or other buildings built before 1978?	☐	☐	☐
2. Does your child live in or visit homes, day care centers or other buildings with recent repairs or remodeling	☐	☐	☐
3. Does your child eat or chew on non-food substances such as paint chips or dirt?	☐	☐	☐
4. Has anyone who lives in the same home as your child previously had an elevated blood lead level?	☐	☐	☐
5. Is your child a foreign adoptee, refugee or has your child recently travelled internationally?	☐	☐	☐
6. Does your child eat wild game such as moose, caribou or waterfowl that has been shot with lead bullets?	☐	☐	☐
7. Does your child come in contact with a person whose job or hobby includes any of the following:	☐	☐	☐

- Chemical preparation
- Valve and pipe fittings
- Brass/Copper foundry
- Refining furniture
- Making fishing weights
- Lead smelting
- Welding
- House construction or repair
- Battery manufacturing or repair
- Burning lead-painted wood
- Automotive repair shop or junk yard
- Going to a firing range or reloading bullets
- Radiator repairs
- Pottery making
- Mining
- Use of lead-containing aviation gas in airplanes or snow-machines

	YES	D/K	NO
8. Does your family use foreign or traditional products such as imported pottery, health remedies, skin care creams, spices, or foods? These include:	☐	☐	☐

- Cosmetics such as kohl, surma, and sindor
- Imported or glazed pottery, imported candy, and imported nutritional pills or vitamins
- Traditional medicines such as ayurvedic, greta, azarcon, alarcon, alkohl, bali goli, coral, ghasard, liga, pay-loo-ah and rueda
- Foods canned or packaged outside the U.S.

For more information, please contact:

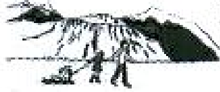
Environmental Public Health Program, AKDHSS

(907) 269-8000

eph@alaska.gov

Updated: 7/30/2019

Glacier Pediatrics



1800 Glacier Ave. • Juneau, AK 99801
Ph: (907) 586-1542 • Fax: (907) 586-1849
Mary Ellen Arvold, PNP • Amy Dressel, MD
Kim Gardner, FNP • Lauren Hopson, PNP

The following form is attached to *all* Well Child Checks, Sport Physicals and Yearly Physicals for patients 5-19 years old. Please have *the patient (if old enough)* fill this form out to the best of their knowledge.

Patient Name: ______________________________ **Patient Date of Birth:**___/___/_____

Who filled out this form: ☐Mom ☐Dad ☐ Myself (The Patient) ☐Other:______________

Please Circle Any Problems The Patient Has Experienced In The Last 6 Months

Acne	Eczema	Menstrual Problems	Warts
Asthma	Ear Infection	Migraines	Weight Concern
Abdominal Pain	Fatigue	Nausea	Vision Problems
Body Aches/Pains	Fevers	Seasonal Allergies	Academic Concerns
Bone/Joint Discomfort	Food Allergies	Seizures	Mood Concerns
Broken Bone(s)	Gastrointestinal Problems	Sexually Transmitted Disease	Social Concerns
Chicken Pox	Headaches	Skin Problems	Behavioral Concerns
Chronic Constipation	Head Injury/Concussion	Urinary Tract Infections	Other:______________
Cough	Hearing Loss	Yeast Infection	______________

Please list any questions or concerns you would like to speak about with your Primary Care Provider:

Question or Concern	Who would you like in the patient exam room when this question or concern is brought up:
1. ______________________	☐Mom ☐Dad ☐Only Myself (The Patient) ☐Doesn't Matter
2. ______________________	☐Mom ☐Dad ☐Only Myself (The Patient) ☐Doesn't Matter
3. ______________________	☐Mom ☐Dad ☐Only Myself (The Patient) ☐Doesn't Matter

THIS FORM IS DOUBLE-SIDED

Have you been to the ER, Urgent Care or any long-term Program Care in the last 12 months: ☐Yes ☐No

If you marked 'Yes', Please see fill out the form below:

Please List Any Hospitalizations, ER Visits, Urgent Care Visits or Program Care in the Last 12 Months		
☐ **No Hospitalization, ER Visits, Urgent Care Visits or Program Care History**		
Reason	Approximate Date	Facility Name

Family Health History

Please let us know who in the child's family has/developed any of the conditions listed below

☐**History is Unknown- The Patient is Adopted or in Foster Care** ☐**No Changes in Family Health History**

Paternal Codes:	Dad (DAD) Grandfather (PGF) Grandmother (PGM)	**Maternal Codes:**	Mom (MOM) Grandfather (MGF) Grandmother (MGM)	**Sibling Codes:**	Brother (BRO) Sister (SIS)

YES	NO	Condition	DAD	PGF	PGM	MOM	MGF	MGM	BRO	SIS
☐	☐	Asthma	☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	Blood Disorders (Anemia, Sickle Cell, Hemophilia)	☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	Bone Problems	☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	Cancer (Specify what type:_____________)	☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	Digestive or Intestinal Problems (Specify:_____________)	☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	Eczema	☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	Hearing Problems	☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	Heart Attack	☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	Joint Problems	☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	Kidney or Bladder Problems	☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	Mental Health (Ex: Depression, Anxiety, Bipolar, Schizophrenia)	☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	Seizures or Epilepsy	☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	Stroke	☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	Substance Abuse (Drugs or Alcohol)	☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	Thyroid Problems / Auto-Immune Conditions	☐	☐	☐	☐	☐	☐	☐	☐
☐	☐	Other:_____________	☐	☐	☐	☐	☐	☐	☐	☐

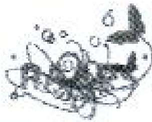
Thank you for helping keep our Primary Care Providers up-to-date in the patients' health history.

The following form contains sensitive information & questions.

You may decline to fill-out this form.

If you have any questions, please contact our office or speak with your provider during your well-check appointment.

-Thank you-



CONFIDENTIAL - ADOLESCENT HEALTH RAAPS

Name: ______________ **Sex:** ________ **Insurance:** ______________

Birthdate: ____________ **Ethnicity/Race:** ____________ **Reg #:** ____________

Health Risk Profile: Confidential **Your answers will only be seen by the center staff**			**Office Use Only**
1. **In the past 12 months**, have you tried to lose weight by obsessively exercising, taking diet pills or laxatives, making yourself vomit (throw up) after eating, or starving yourself?	No	Yes	
2. Do you eat some fruits and vegetables every day?	Yes	No	
3. Are you active after school or on weekends (walking, running, dancing, swimming, biking, playing sports) for **at least 1 hour, on at least 3 or more days each week?**	Yes	No	
4. Do you **always** wear a lap/seat belt when you are driving or riding in a car, truck, or van?	Yes	No	
5. Do you **always** wear a helmet when you are biking, rollerblading, skateboarding, motorcycling, snowmobiling, skiing or snowboarding?	Yes	No	
6. **During the past month**, have you been threatened, teased, or hurt by someone (on the internet, by text, or in person) or has anyone made you feel sad, unsafe, or afraid?	No	Yes	
7. Has anyone **ever abused** you physically (hit, slapped, kicked), emotionally (threatened or made you feel afraid) or **forced you** to have sex or be involved in sexual activities when you didn't want to?	No	Yes	
8. Have you **ever** carried a weapon (gun, knife, club, other) to protect yourself?	No	Yes	
9. **In the past 3 months**, have you smoked cigarettes or any other form of tobacco (cigars, black and mild, hookah, other) or chewed/used smokeless tobacco?	No	Yes	
10. **In the past 12 months**, have you driven a car drunk, high, or while texting or ridden in a car with a driver who was?	No	Yes	
11. **In the past 3 months**, have you drunk more than a few sips of alcohol (beer, wine coolers, liquor, other)?	No	Yes	
12. **In the past 3 months**, have you smoked marijuana, used other street drugs, steroids, or sniffed inhalants ("huffed" household products)?	No	Yes	
13. **In the past 3 months**, have you used **someone else's** prescription (from a doctor or other health provider) or any nonprescription (from a store) drugs to sleep, stay awake, concentrate, calm down, or get high?	No	Yes	
14. Have you **ever** had any type of sex (vaginal, anal or oral sex)?	No	Yes	
15. Have you ever been attracted to the same sex (girl to girl/guy to guy) or do you feel that you are gay, lesbian, or bisexual?	No	Yes	
16. If you have had sex, do you **always** use a method to prevent sexually transmitted infections and pregnancy (condoms, female barriers, other)?	Yes	No	
17. **During the past month**, did you **often** feel sad or down as though you had nothing to look forward to?	No	Yes	
18. Do you have any serious problems or worries at home or at school?	No	Yes	
19. **In the past 12 months**, have you seriously thought about killing yourself, tried to kill yourself, or have you purposely cut, burned or otherwise hurt yourself?	No	Yes	
20. Do you have at least one adult in your life that you can talk to about any problems or worries?	Yes	No	
21. When you are angry, do you do things that get you in trouble?	No	Yes	

For Office Use Only

Evaluation: ________ At Risk Counseled ________ At Risk Needs f/u ________ No Current Risk **Referred to:** ____________

Provider Signature: ______________________ **Date:** ____________

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