



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? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Does your child live in or visit homes, day care centers or other buildings with recent repairs or remodeling? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Does your child eat or chew on non-food substances such as paint chips or dirt? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Has anyone who lives in the same home as your child previously had an elevated blood lead level? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Is your child a foreign adoptee, refugee or has your child recently travelled internationally? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Does your child eat wild game such as moose, caribou or waterfowl that has been shot with lead bullets? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Does your child come in contact with a person whose job or hobby includes any of the following: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <ul style="list-style-type: none"> • Chemical preparation • Valve and pipe fittings • Brass/Copper foundry • Refining furniture • Making fishing weights • Lead smelting • Welding | <ul style="list-style-type: none"> • 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 | <ul style="list-style-type: none"> • Mining • Use of lead-containing aviation gas in airplanes or snow-machines | |
| 8. Does your family use foreign or traditional products such as imported pottery, health remedies, skin care creams, spices, or foods? These include: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <ul style="list-style-type: none"> • 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

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1600 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		
<input type="checkbox"/> 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											
<input type="checkbox"/> History is Unknown- The Patient is Adopted or in Foster Care <input type="checkbox"/> 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				Who:					
			DAD	PGF	PGM	MOM	MGF	MGM	BRO	SIS	
<input type="checkbox"/>	<input type="checkbox"/>	Asthma				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorders (Anemia, Sickle Cell, Hemophilia)				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Bone Problems				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Cancer (Specify what type: _____)				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Digestive or Intestinal Problems (Specify: _____)				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Eczema				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Hearing Problems				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Joint Problems				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Kidney or Bladder Problems				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Mental Health (Ex: Depression, Anxiety, Bipolar, Schizophrenia)				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Seizures or Epilepsy				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Stroke				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Substance Abuse (Drugs or Alcohol)				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems / Auto-Immune Conditions				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

I understand and acknowledge that as of my 18th birthday, I am considered an adult and I am responsible for my own healthcare. By law, my parents/guardians will no longer be permitted access to my medical records or be able to participate in my healthcare with providers without my specific written permission. **Please select the level of consent from option 1 or option 2.**

Option 1

I am giving written permission for the following parents/guardians to participate in my healthcare:

Please initial all that apply:

- Request/Receive Medical Records
- Request Prescriptions
- Pick up controlled substance prescriptions
- Speak to a Triage Nurse and receive medical advice on my behalf
- Speak to a physician and receive medical advice on my behalf
- Make appointments on my behalf

PLEASE READ THE FOLLOWING CAREFULLY:

- Medical staff **CAN** speak about sensitive conditions including drug or alcohol use, pregnancy, sexual activity, sexually-transmitted disease and/or mental health issues
- Medical staff **CANNOT** speak about sensitive conditions including drug or alcohol use, pregnancy, sexual activity, sexually-transmitted disease and/or mental health issues

List person(s) authorized for the activities initialed above:

- | Name: | Relationship to Patient: |
|----------|---|
| 1. _____ | <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other: _____ |
| 2. _____ | <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other: _____ |
| 3. _____ | <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other: _____ |

Preferred Phone Number List:

- My Personal Phone Number: (____) _____
- | | |
|-----------------|---|
| 1. (____) _____ | <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other: _____ |
| 2. (____) _____ | <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other: _____ |

Option 2

I am declining to give anyone permission to participate in all levels of my healthcare. I understand that by initialing this box nobody except for myself can receive/request medical records, make appointments or speak to a nurse/physician about my health status.

I do not give consent for anyone to participate in my healthcare.

My Personal Phone Number: (____) _____

I understand I can withdraw this consent at any time by providing Glacier Pediatrics with written notice indicating the changes in access

 Patient Name: _____ Patient Date of Birth: _____
 Patient Signature: _____ Date: _____

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-



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 _____ At Risk _____ No Current _____ Referred to: _____
 _____ Counseled _____ Needs f/u _____ Risk _____

Provider Signature: _____ Date: _____