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

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

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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	Who: 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.