# MARYLAND HEALTHY KIDS PROGRAM

## Preventive Screen Questionnaire

| **Lead Risk Assessment:** *(every well child visit from 6 months up to 6 years)* | **Date** ____ | **Date** ____ | **Date** ____ | **Date** ____ | **Date** ____ | **Date** ____ | **Date** ____ |
|---|---|---|---|---|---|---|---|
| 1. Has your child ever lived or stayed in a house or apartment that is built before 1978? (includes day care center, preschool home, home of babysitter or relative) | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
| 2. Is anyone in the home being treated or followed for lead poisoning? | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
| 3. Are there any current renovations or peeling paint in a home that your child regularly visits? | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
| 4. Does your child lick, eat or chew things that are not food? (paint chips, dirt, railings, poles, furniture, old toys, etc.) | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
| 5. Is there any family member who is currently working in an occupation or hobby where lead exposure could occur? (auto mechanic, ceramics, commercial painter, etc.) | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |

*(A "yes" or "don't know" response to any question indicates a positive risk)*

| **Tuberculosis Risk Assessment:** *(Starting at 6 months of age and annually thereafter)* | **Date** ____ | **Date** ____ | **Date** ____ | **Date** ____ | **Date** ____ | **Date** ____ | **Date** ____ |
|---|---|---|---|---|---|---|---|
| 1. Has your child been exposed to anyone with a case of TB? | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
| 2. Was your child, or a household member, born in an area where TB is common (e.g., Africa, Asia, Latin America, and the Caribbean)? | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
| 3. Has your child, or a household member, lived more than a year in an area where TB is common? | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
| 4. Does your child have daily contact with adults at high risk for TB (e.g., those who are HIV infected, homeless, incarcerated, and/or illicit drug users)? | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
| 5. Does your child have HIV infection? | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |

*(A "yes" or "don't know" response to any question indicates a positive risk)*

**Patient Name:** _____ **Birth Date:** _____

# MARYLAND HEALTHY KIDS PROGRAM

## Preventive Screen Questionnaire

| **Heart Disease/Cholesterol Risk Assessment:** *(2 years through 20 years)* | **Date** | **Date** | **Date** | **Date** | **Date** | **Date** | **Date** |
|---|---|---|---|---|---|---|---|
| 1. Is there a family history of parents/grandparents under 55 years of age with a heart attack, heart surgery, angina or sudden cardiac death? | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
| 2. Has the child's mother or father been diagnosed with high cholesterol? (240 mg/dL or higher) | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
| 3. Is the child/adolescent overweight? (BMI > 85th %) | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
| 4. And is there a personal history of: | | | | | | | |
| Smoking? | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
| Lack of physical activity? | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
| High blood pressure? | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
| High cholesterol? | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
| Diabetes mellitus? | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |

*(Refer to the AAP Clinical Guidelines for Childhood Lipid Screening)*

| **STI/HIV Risk Assessment:** *(12 years through 20 years)* | **Date** | **Date** | **Date** | **Date** | **Date** | **Date** | **Date** |
|---|---|---|---|---|---|---|---|
| 1. Have you had a blood transfusion or are you a Hemophiliac? | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
| 2. Have you ever been sexually molested or physically attacked? | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
| 3. Have you ever been diagnosed with any sexually transmitted diseases? | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
| 4. Any history of IV drug use by you, your sex partner, or your birth mother during pregnancy? | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
| 5. If sexually active, have you had unprotected sex, with opposite/same sex? | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
| 6. If sexually active, have you had more than one partner? | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
| 7. Any body tattoos or body piercing of ears, navel, etc, including any performed by friends? | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |

***(A "yes" response to any question indicates a positive risk)***

**Patient Name:** _____ **Birth Date:** _____