COMPLETE BOTH SIDES PLEASE

Patient's full name: _____ **Date**: _____

FAMILY MEDICAL HISTORY

Does anyone in your family, alive or deceased, suffer from the following illnesses? If so, please state the relationship to the child, i.e. mother, sister, etc. and specific illness, i.e. hole in heart, etc. We are only interested in parents of the child, and aunts, uncles, and grandparents of the child.

1. Alcoholism/Substance Abuse: _____
2. Cardiovascular Disease/Hypertension High Cholesterol & Triglycerides/ Heart Attacks/Coronary Bypass/Irregular heart beat: _____
3. Cancers of any type: _____
4. Blood problems/ Anemia/ Bleeds too easily/Clots too Easily: _____
5. Bone Problems/Osteopenia/Osteoporosis: _____
6. Arthritis: _____
7. Endocrine Illnesses/Thyroid/Diabetes: _____
8. Diseases of the Stomach or Intestine system/Celiac/Crohns/IBS/ GERD: _____
9. Developmental Problems/slow to learn to walk or talk/Failure to do so: _____
10. Learning problems/Dyslexia/ADHD/Learning Disability: _____
11. Neurologic Disease- Seizures, Multiple Sclerosis: _____
12. Psychiatric Disorders-Bipolar/Anxiety/Depression or Schizophrenia: _____
13. Congenital Deformity/Deafness/Visual Problems: _____
14. Kidney/Lung/Skin, Bone, Muscle diseases: _____

BLOOD LEAD TESTING REQUIREMENTS

For Ohio Children, less than 6 Years of Age

If over 6 Years skip to other side.

If the family answers "yes" or "do not know" to any question below then **TEST-IT'S OHIO LAW**	**YES**	**DO NOT KNOW**	**NO**
1. Does the child live in or regularly visit a property built before 1978 that has peeling/chipping paint or recent/ongoing renovations? If "yes" or "do not know," **TEST-IT'S OHIO LAW!** If "no go to 2.			
2. Does the child live in a high-risk Zip code (see list on back) If "yes" or "do not know," **TEST-IT'S OHIO LAW!** If "no go to 4.			
3. Ask the parent six key question to assess risk. If "yes" or "do not know," **TEST-IT'S OHIO LAW!** If "no go to 2.			
• Does your child live in or regularly visit a home built before 1950?			
• Does your child have a sibling or playmate who has or did have lead poisoning?			
• Does your child frequently come in contact with an adult who has a hobby or works with lead? Examples are construction, welding, pottery, painting, and casting ammunition.			
• Did the child's mother have known lead exposure during her pregnancy with the child?			
• Is the child or his/her mother an immigrant or refugee?			
• Does your child live near an active or former lead smelter, battery recycling plant, or other industry known to release lead?			

Butler:	Clermont	Fairfield	Hamilton					Montgomery			Kentucky	Campbell	Bracken	Kenton
45003	45130	43130	45052	45213	45225	45238	45251	46066	45414	45432		41071	41002	41011
45004	45244	43155	45201	45214	45226	45239	45252	45325	45415	45433		41073	41004	41014
45011	45255		45002	45215	45227	45240	45255	45401	45416	45439		41074		41015
45012			45203	45216	45229	45241	45299	45402	45417	45440		41085		41016
45013			45204	45217	45230	45242		45403	45419	45449				
45014			45205	45218	45231	45243		45404	45420	45458				
45015			45206	45219	45232	45244		45405	45422	45459				
45042			45207	45220	45233	45246		45406	45424	45470				
45044			45208	45221	45234	45247		45407	45426					
45062			45209	45222	45235	45248		45409	45428					
45241			45211	45234	45236	45249		45410	45429					
45246			45212	45224	45237	45250		45412	45431					

PEDIATRIC TUBERCULOSIS SCREENING QUESTIONNAIRE

Has your child had any contact with persons or cases of TB? Y/N
Was your child born in and or spent more than 30 days in a country other than USA? Y/N
Does your child have regular contact with adults at high risk for TB (HIV infected, homeless, incarcerated, and/or illicit drug users)? Y/N
Does your child have HIV infection? Y/N

Has your child had recurrent complaints in any of the following areas?
Please circle all that apply.

- abdominal pain
- allergies/asthma/lung disease
- anxiety /depression
- attention/learning disorders
- blood in urine/stool
- bone/joint/muscle pain
- chest pain/breathing difficulty
- difficulty with urination/bowel movements
- headaches
- hearing difficulties
- major stress
- menstrual pain/complaints
- nasal obstruction/mouth breathing
- rapid heart beat
- skin problems
- sleep disorders
- vaginal/urethral discharge
- visual problems

Has your child ever been hospitalized? Y/N Why_____
Has your child had surgery? Y/N Why _____
Is your child allergic to any medications?
Does your child have any other allergies?
How many children are there within your home?
Do you use city drinking water? Y/N If not, does your water source contain fluoride? Y/N
Does anyone smoke in the home or at the child's care giver's home? Y/N
Does anyone have problems with alcohol or drug abuse? Y/N

Does either parent have an occupation hobby that exposes the child to environmental hazards? Y/N
Example: asbestosis/pesticides/microbes/lead.

Reviewed by: _____ Completed by: _____