

Administered by:	Date: / /

## Childhood Lead Risk Questionnaire

For assessing lead exposures in children.

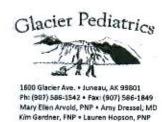
Instructions	: 1. Ask the ch	nild's parent or gu	ardian the f	ollowing questions	and mark their responses.			
	2. If guardian	n answers YES or	Don't Know	v (D/K) to any que	stion, test the child for lead a	s soon	as poss	sible.
Child's Name:								
Date of Birth:		1	Age:	years				
Gender (circle one):	MALE	FEMALE						
Provider's Name:								
Please answer YE	S, Don't Know	v (D/K) or NO to t	ne following	questions:				
						YES	D/K	NO
1. Does your child	live in or visit	homes, day care	centers or o	other buildings buil	t 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 o	n non-food substa	ances such	as paint chips or o	iirt?			
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 p	preparation	• Ho	use constru	ection or repair	Mining			
Valve and pipe fittings			ttery manuf	acturing or repair	Use of lead-cont	taining		
Brass/Copper foundry     Burn			ming lead-	painted wood	aviation gas in air			
<ul> <li>Refining fu</li> </ul>	or snow-machines  • Automotive repair shop or Junk yard				5			
<ul> <li>Making fist</li> </ul>	hing weights	• Go	ing to a firit	ng range or reload	ing bullets			
<ul> <li>Lead smelt</li> </ul>	ting	• Ra	diator repai	rs				
<ul> <li>Welding</li> </ul>		• Po	ttery makin	9				
8. Does your family	y use foreign o	or traditional produ	ucts such a	s imported pottery	health remedies, skin care			
creams, spices,	or foods? The	ese include:						
<ul> <li>Cosmetics</li> </ul>	such as kohl,	surma, and sind	or					
<ul> <li>Imported o</li> </ul>	or glazed potte	ry, imported cand	y, and impo	orted nutritional pill	s or vitamins			
<ul> <li>Traditional</li> </ul>	medicines suc	ch as ayurvedic, g	reta, azarco	on, alarcon, alkohl,	bali goli, coral, ghasard, liga,	pay-loc	-ah an	d rueda
		ged outside the U				1,000		

For more information, please contact:

Environmental Public Health Program, AKDHSS (907) 269-8000

eph@alaska.gov

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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 Birt	h:/					
Who filled out t	his form:   Mom   Dad   M	Myself (The Patient)    Other:						
Please	e Circle Any Problems The Patio	ent Has Evnerienced In The La	set 6 Months					
cne	Eczema	Menstrual Problems	Warts					
sthma	Ear Infection	Migraines	Weight Concern					
bdominal Pain	Fatigue	Nausea	Vision Problems					
ody Aches/Pains	Fevers	Seasonal Allergies	Academic Concerns					
one/Joint Discomfort	Food Allergies	Seizures	Mood Concerns					
roken Bone(s)	Gastrointestinal Problems	Sexually Transmitted Disease	Social Concerns					
hicken Pox	Headaches	Skin Problems	Behavioral Concerns					
hronic Constipation Head Injury/Concussion		<b>Urinary Tract Infections</b>	Other:					
ough	Hearing Loss	Yeast Infection						
	estions or concerns you would	Who would you like in the	Primary Care Provider: patient exam room when this ncern is brought up:					
•		□Mom □Dad □ <b>Only M</b> ys	elf (The Patient) Doesn't Matter					
L.		□Mom □Dad □ <b>Only</b> Mys	elf (The Patient) Doesn't Matter					
		— □Mom □Dad □ <b>Only</b> Mys	self (The Patient) Doesn't Matter					

## THIS FORM IS DOUBLE-SIDED

H			he ER, Urgent Ca ed 'Yes', Please s	0.00000	ng-term Program Ca he form below:	re in	the l	ast 1	12 m	onth	s: 🗆	Yes	□Ne	0
	P	lease List Ar	ny Hospitalizations	, ER Visits, Ur	gent Care Visits or Pr	ogran	n Car	e in t	he La	st 12	Mo	nths		
			No Hospitalizati	on, ER Visits,	Urgent Care Visits or	r Prog	gram (	Care	Histo	ory				
Reason Approximate Date						Facility Name								
										_				
				Family	Health History									
					y has/developed any									
	LIHIS	Paternal	Dad (DAD)	Maternal	or in Foster Care  Mom (MOM)	Sibl		s in F		er (BRO	_	listor	У	
		Codes:	Grandfather (PGF)	Codes:	Grandfather (MGF)	Cod	-		Sister					
YES	NO	Condition	Grandmother (PGM)		Grandmother (MGM)		Wh	0.						
165	110	Contaction					DAD	PGF	PGM	мом	MGF	MGM	BRO	SIS
		Asthma												
		Blood Disorders (Anemia, Sickle Cell, Hemophilia)												
		Bone Problems												
		Cancer (Sp	ecify what type:			)								
		Diabetes								0				
		Digestive or Intestinal Problems (Specify:)												0
		Eczema	W.											
		Hearing Pr												
		Heart Atta	0.444											
		Heart Dise												
		High Blood												
		High Chole												
		Joint Probl							0					0
			Bladder Problems	a Amilata D	inalaa Sabinanbuania	`			0					
		0.00 - 0.00 0.00 0.00 0.00 0.00		on, Anxiety, B	ipolar, Schizophrenia	,				0				
		Seizures or Stroke	rhuchsy						0	0		-		
		C-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1	Abuse (Drugs or A	(cohol)					0					
			oblems / Auto-Imr		ons									
		Other:												