Health Screening Questionnaire

Patient Name: _____ Date of Birth: _____ Date of Screening: _____

Questions for Parent/Guardian

1. Were you, primary caregiver, or your child born outside of the United States? Yes □ No □

If yes, who? _____

If yes: Where were you and/or your child born? _____

Did you receive a BCG? Yes □ No □ Did your child receive a BCG? Yes □ No □

2. Has your child traveled outside of the United States within the last 2 years? Yes □ No □

If yes: Where did your child travel? _____

With whom did your child stay? _____

How long did your child stay there? _____

Dates of travel (month/year): _____

3. To your knowledge, has your child been exposed to anyone with TB disease or with a person who has had a positive TB skin test? Yes □ No □

If yes, please answer these questions:

Do you know if the person had TB disease or latent TB infection (LTBI)?

□ TB disease □ LTBI □ Don't Know

When did your child last have contact with that person?_____

What was the nature of that contact? _____

Was the contact treated? _____

4. Does your child have any of the following chronic medical conditions? *Diabetes, HIV/AIDS, Renal Failure, Immunological deficiency, Leukemia or Lymphoma, currently on immunosuppressive therapy or receiving chemotherapy, or high dose steroids* Yes □ No □

5. Has your child had close contact with a resident of an institution? *(Nursing home, correctional facility, inpatient treatment facility)* Yes □ No □

If yes, when did your child last have contact? _____

_____

FOR CHILDREN 2 YEARS OR OLDER:

1. Has any parent, grandparent, uncle, aunt, or sibling of your child had a stroke, heart attack, or bypass surgery before the age of 55 years? Yes _____ No_____
2. Has either mother or father of child been told they have a "high cholesterol" level or is currently taking cholesterol lowering medications? Yes_____ No_____

FOR CHILDREN 6 YEARS OR YOUNGER:

1. Does your child live in or regularly visit a home, preschool, or daycare built before 1978? **Y N**
2. Is there a sibling, household contact or playmate being followed or treated for lead poisoning? **Y N**
3. Does any household contact have a hobby or occupation involving possible lead exposure? **Y N**
4. Does your child live near active lead smelter, batter recycling plant, or any industry likely to release lead? **Y N**
5. Do you suspect your child has been exposed to lead? **Y N**
6. Does your child receive Medicare or WIC? **Y N**
7. What is your zip code? _____