6 Month to 3 Year Visit Questionnaire

Patient's Last Name: _____ **First Name:** _____ **Birthdate:**_____ **Today's Date:**_____

	CIRCLE		*(If yes, explain below)
General:			
Do you have any specific concerns for today's visit?	No	Yes*	
Is your child taking any prescription medications?	No	Yes*	
Are your child's vaccines covered by your insurance plan?	No	Yes	
Is your child seeing a specialist for any ongoing medical problem(s)?	No	Yes*	
Has your child been seen in a hospital ER or treatment center since the last visit here?	No	Yes*	
Does your child have any ongoing medical problems or diagnosis? (If yes, please list on bottom.)	No	Yes*	
Family Medical:			
Do the parents have any significant medical issues that we should be aware of?	No	Yes*	
Have there been any other significant family medical issues recently?	No	Yes*	
Social:			
Are the biological parents married?	No	Yes	
Are there any new stressful events, losses, deaths, job changes, or social issues of concern recently?	No	Yes*	
Are there any smokers in the household? (If yes, please indicate who)	No	Yes*	
Do you have any concerns regarding domestic abuse or child abuse in your household?	No	Yes*	
Symptom Review:			
Has your child had any fever (over 100.4), runny nose or significant cough in the last 3 days?	No	Yes*	
Do you have any concerns regarding your child's sleep habits?	No	Yes*	
Do you have any concerns regarding your child's behavior?	No	Yes*	
Do you notice problems with eye muscle alignment, drifting, crossing or laziness?	No	Yes*	
Does your child have ongoing eye redness or discharge?	No	Yes*	
Do you have any concerns regarding your child's hearing?	No	Yes*	
Is the child having any significant breathing problems that you are concerned about?	No	Yes*	
Has your child had episodes of vomiting recently?	No	Yes*	
Do you have any concerns regarding your child's stooling habits?	No	Yes*	
Do you have any concerns regarding the child's use of his/her legs or arms?	No	Yes*	
Do you have any concerns regarding your child's voiding/urinary habits?	No	Yes*	
Does your child have any unusual rashes that you are concerned about?	No	Yes*	

*Explain 'YES" Answers: _____

_____

State of Illinois
Illinois Department of Public Health

Childhood Lead Risk Questionnaire

Patient's Last Name: _____ **First Name:** _____ **Today's Date:** _____

Age _____ **Birthdate:** _____ **Zip Code:** _____

STATE LAW REQUIRES:
All children 6 years of age or younger must be evaluated for lead exposure.
All children must be assessed for risk of lead exposure and tested if necessary for enrollment into daycare, preschool, and kindergarten.

Complete the Childhood Lead Risk Questionnaire during a well-child or health care visit for children ages 12 and 24 months of age (at minimum) and once a year at annual well-child-visits at ages 3, 4, 5, and 6 years.

- If responses to all the questions are "NO," re-evaluate at next age referenced above or more often if deemed necessary.
- If any response is "YES" or "DON'T KNOW," a blood lead test *must* be obtained.
- If there are any "YES" or "DON"T KNOW" answers *and*
  - ✓ previous blood lead testing was done at 12 and 24 months of age with a result of 4.9 µg/dL or less OR if not performed at 12 and 24 months, a blood lead test was performed at 3, 4, 5, or 6 years of age with a result of 4.9 µg/dL or less, and
  - ✓ there has been no change in address of the child's home/residential building, child care facility, school, or other frequently visited facilities and
  - ✓ risks of exposure to lead have not changed, further blood lead tests are not necessary.

Respond to the following questions by circling the appropriate answer.	RESPONSE		
1. Does this child reside or regularly visit a home/residential building, child-care setting, school or other facility built before 1978 or in a high risk ZIP code area? (see reverse side of page for high risk ZIP code area list)	Yes	No	Don't Know
2. Is this child eligible for or enrolled in Medicaid, All Kids, Head Start, WIC, or any HFS medical program? ***All Medicaid-eligible children and children enrolled in HFS medical programs shall have a blood lead test at 12 and at 24 months of age. If a Medicaid-eligible child or HFS medical program enrolled child between 36 months and 72 months of age has not been previously tested, a blood lead test shall be performed.	Yes	No	Don't Know
3. Does this child have a sibling with a confirmed blood lead level of 5 µg/dL or higher?	Yes	No	Don't Know
4. In the past year, has this child been exposed to repairs, repainting, or renovation of a building/home built before 1978?	Yes	No	Don't Know
5. Is this child a refugee, adoptee, or recent visitor of any foreign country?	Yes	No	Don't Know
6. Is this child frequently exposed to imported items (such as, ayurvedic medicine, folk medicines, cosmetics, toys, glazed pottery, spices or other food items, sindoor, or kumkum)?	Yes	No	Don't Know
7. Does this child live with someone who has a job or a hobby that may involve lead (for example; jewelry making, building renovation, bridge construction, plumbing, furniture refinishing, work with automobile batteries or radiators, lead solder, leaded glass, bullets, lead fishing sinkers, or recycling facility work)?	Yes	No	Don't Know
8. If the child is younger than 12 months of age, did the child's mother have a past confirmed blood lead level of 5 µg/dL or higher?	Yes	No	Don't Know
9. Has the water in your home/residential building, child-care setting, school, or other regularly visited facility been tested and had a confirmed level of lead (5 ppb or higher)?	Yes	No	Don't Know
10. Does your child live near an active lead smelter, battery recycling plant, or another industry likely to release lead, or does your child live near a heavily-traveled road where soil and dust may be contaminated with lead?	Yes	No	Don't Know

*****ALL blood lead test results MUST be submitted to the Illinois Lead Program.**
Fax: 217-557-1188 Phone: 866-909-3572

_____ _____
Signature of Doctor/Nurse *Date*

Illinois Lead Program 866-909-3572 or 217-782-3517 email: dph.lead@illinois.gov
TTY (hearing impaired use only) 800-547-0466

Patient Last Name: _____ **First Name:** _____

Birthdate: _____ **Today's Date:** _____

PEDIATRIC WELLNESS QUESTIONAIRE AND ACTION PLAN (AGES 2-21 YEARS)

Nutrition

Please estimate the average number of total servings per day of both fruits and vegetables:
(1 serving is about 1/2 cup)

☐1 or less ☐2 ☐3 ☐4 ☐5 or more

Goal: 5 or more servings per day fruits and vegetables is recommended.

Please estimate the average number of total servings per day of water:

☐1 or less ☐2 ☐3 ☐4 or more

Goal: 4 or more servings per day of water is recommended.

Please estimate the average number of total servings of the following:

Milk (either cow's milk or other milk substitute): ☐none ☐1 ☐2 ☐3 or more

Other dairy (i.e. cheese, yogurt, ice cream): ☐none ☐1 ☐2 ☐3 or more

Please indicate the type of milk: ☐FAT FREE ☐1% ☐2% ☐WHOLE ☐OTHER_____

Goal: 3 or more total calcium containing food/beverage servings per day is recommended for adequate daily calcium intake. If you are not meeting this requirement, then please discuss with your provider the role of calcium supplements.

Does the patient take a daily multiple vitamin? ☐YES ☐NO

Physical Activity

Please estimate the total number of average time per day spent physically active– please include any sports, gym class in school, running around, biking, active play time, or any non-sedentary activity. Averaging implies that if two hours of activity one day and none the next day, then that would average to 1 hr per day:

Approx time per day in hours: ☐Less than 1 hour ☐1 hour or more

Goal: An average of 1 hour or more per day of physical activity is recommended.

Screen Time

Please estimate the average amount of time per day spent watching TV, using recreational computer, or video gaming (do not include computer time used for school or work based homework):

Approx time per day in hours: ☐Less than 2 hours ☐2 hours or more

Goal: Total recreational screen time should average less than 2 hours per day.

Hypertension Counseling

Hypertension, also known as high blood pressure, is very common among adults, but can also occur in children and teenagers. Healthy lifestyles begun during childhood can help lower the risk of hypertension in adulthood, including (1) maintaining a healthy weight, (2) regular aerobic type exercise sustained all year long, (3) modest salt intake, and (4) learning to manage stress in an effective and positive manner. Another important component is regular yearly physical exams to monitor and check blood pressure beginning in childhood. Family history is also an important risk factor. Lastly, hypertension often has no symptoms and may go undetected without regular exams.