Well Child Questionnaire

Name: _____ **Date:** _____

Do you have any concerns about your child today? ___Yes ___No

_____

When was last well exam (age)? _____ Has your child seen a dentist? __Yes __No

Do you vaccinate your child? __Yes __No Are the vaccinations up to date? __Yes ___No

Does your child see any specialists? __Yes __No

Doctor	Condition seen for
_____	_____
_____	_____
_____	_____
_____	_____

Social/Environmental History
Parents (circle): married, separated, living together

Who lives with the child: _____

Do parents work outside of the home? **__Yes __No**

School Attended and Grade: _____

Daycare/MDO: _____

Problems and home or school: ___Yes ____No _____

Where does the child sleep? _____ Does your child sleep well? ___Yes ___No

Does your child use a car/booster seat? __Yes __No Smokers in/out of the home? ___Yes ___No

Is your house childproofed? ___Yes ___No Guns in the home? ___Yes ___No

Is child in sports/school activities? ___Yes ___No _____

Problems going to the restroom? ___Yes ___No _____

Feeding/Diet: (circle all that apply)

Infants/Toddlers:	**Children/Teens**
Breast/Bottle	Healthy diet
Table food/Gerber _____jars per day	Little junk Food
Formula/Cow's Milk/Other ____oz per day	Mostly junk Food

_____

Patient Tobacco History (older than 13 years old)
Never smoker **__Yes ___No**
Current smoker **__Yes ___No**
Former smoker **__Yes ___No**

Menstrual Cycle
Has started period ___Yes ___No Age of first period: _____Years
Has monthly period ___Yes ___No Last menstrual period _____

Hearing Checklist for Parents

Client Information

Name: _____

DOB: _____/_____/_____ Age: _____ Sex: _____

SSN/Record No.: _____

Race/Ethnicity: _____

Informant/Relationship: _____

Medical Home: _____

Age 0 to 3 Yrs	Yes	No	
0 to 3 months	❑	❑	Does your baby get quiet for a moment when you talk to him/her?
	❑	❑	Does your baby act startled or stop moving for a moment when there are sudden loud noises?
4 to 6 months	❑	❑	Does your baby turn his/her eyes or head to the sound of your voice if he/she cannot see you?
	❑	❑	Does your baby smile or stop crying when you or someone else he/she knows speaks?
7 to 9 months	❑	❑	Does your baby stop and pay attention when you say "no" or call his/her name?
	❑	❑	Does your baby move his/her head around to try and find out where a new sound is coming from?
	❑	❑	Does your baby make strings of sounds ("ba ba ba, da da da")?
10 to 15 months	❑	❑	Does your baby give you toys or other objects (bottle) when you ask, without your having to use a gesture (holding out your hand or pointing)?
	❑	❑	Does your baby point to familiar objects if you ask ("dog," "light")?
16 to 24 months	❑	❑	Does your child use his/her voice most of the time to get what he/she wants or to communicate with you?
	❑	❑	Can your child go get familiar objects that are kept in a regular place if you ask him/her ("Get your shoes.")?
25 to 36 months	❑	❑	Does your child answer different kinds of questions ("When...," "Who...," "What...,")?
	❑	❑	Does your child notice different sounds (telephone ringing, shouting, doorbell)?

If you answered "no" to any of the above questions, ask your doctor about a hearing test for your baby. Babies can be tested as soon as the day of birth.

Date of visit	Age	Result	Signature of Provider
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TEXAS Department of State Health Services

Department of State Health Services
Publication No. EFO5-12234
8/05

Questions About Your Child and Tuberculosis (TB)

Child's Name_____Date of Birth _____

Your Name _____

Today's Date _____

We need your help to find out if your child has been exposed to the disease tuberculosis, also known as TB.

TB is caused by germs. It is usually spread to another person by coughing or sneezing. A person can have TB germs in their body but not have active TB disease. TB can be prevented and treated. Your answers to the questions below will let us know if your child might have been exposed to TB. If your answers show your child might have picked up the TB germs, we will want to give him or her a tuberculin skin test (TST). The skin test is not a vaccination. It will not prevent TB. It will only let us know if your child has the TB germs.

Check the box that matches your answer:	Yes	No	Do Not Know
1. Has your child been tested for TB? If yes, when? Please tell us the date / /			
2. Have you ever been told that your child had a positive tuberculin skin test (TST)? If yes, when? Please tell us the date / /			
3. TB can cause fever that can last days or weeks. It can cause weight loss, a bad cough (lasting over two weeks), or coughing up blood.			
a. Has your child been around anyone with any of these problems?			
b. Has your child been around anyone sick with TB?			
c. Has your child ever had any of these problems or do they have them now?			
4. Was your child born in another part of the world like Mexico or Latin America, the Caribbean, Africa, Eastern Europe, or Asia?			
5. Has your child been to Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe, or Asia for more than 3 weeks? Which country or countries did your child visit?_____			
6. Do you know if your child has spent more than 3 weeks with anyone who:			
Uses needles for drug use?			
Has AIDS?			
Was or is in jail or prison?			
Has just come to the United States from another country?			

FOR THE PROVIDER:

If the prior test was negative and the answer to #4 is yes, the child does not need a repeat skin test.
If the prior test was negative and occurred at least 8 weeks after the situation described in #3a, 3b, 5, or 6, the child does not need a repeat skin test.
If the prior test was positive, the child does not need a repeat skin test; but a positive answer to #3c would indicate a chest x-ray as soon as possible.

TST administered Yes____ No____

I yes, Date administered ____/____/____ Date read ____/____/____ TST reaction _____mm

TST provider _____ _____
Signature Printed Name

If chest x-ray done, date ____/____/____ and results_____

Provider phone number (____) _____ City_____ County _____

If positive, referral to local/regional health department/specialist? Yes____No____

If yes, name of health dept./specialist _____

Contact your local or regional health department if assistance is needed.

TEXAS Health and Human Services

Texas Department of State Health Services

Lead Risk Questionnaire

Form Pb-110

Purpose: To identify children who need to be tested for lead exposure.

Instructions

- If **Yes or Don't Know**, test the child immediately.
- You may administer a blood lead test instead of using this questionnaire.
- For more information, contact the Texas Childhood Lead Poisoning Prevention Program at: 1-800-588-1248.

Patient's Name: _____ **DOB:**_____ **Medicaid #:** _____

Provider's Name: _____ **Administered by:**_____ **Date** _____

Questions	Yes or Don't Know	No
1. Does your child live in or visit a home, day-care or other building built before 1978?	☐	☐
2. Does your child live in or visit a home, day-care or other building with ongoing repairs or remodeling?	☐	☐
3. Does your child eat or chew on non-food things like paint chips or dirt?	☐	☐
4. Does your child have a family member or friend who has or did have an elevated blood lead level?	☐	☐
5. Is your child a newly arrived refugee or foreign adoptee?	☐	☐
6. Does your child come in contact with an adult whose job or hobby involves lead exposure?	☐	☐
Examples • House construction or repair • Battery manufacturing or repair • Burning lead-painted wood • Automotive repair shop or junk yard • Going to a firing range or reloading bullets • Chemical preparation • Valve and pipe fittings • Brass/copper foundry • Refinishing furniture • Making fishing weights • Radiator repair • Pottery making • Lead smelting • Welding		
7. Does your family use products from other countries such as pottery, health remedies, spices, or food?	☐	☐
Examples • Traditional medicines such as Ayurvedic, greta, azarcón, alarcón, alkohl, bali goli, coral, ghasard, liga, pay-loo-ah, and rueda • Cosmetics such as kohl, surma, and sindor • Imported or glazed pottery, imported candy, and imported nutritional pills other than vitamins. • Foods canned or packaged outside the U.S.		
	Test Immediately	

TEXAS Health and Human Services | Texas Department of State Health Services

Parent Decision Form for Storage and Use of Newborn Screening Blood Spot Cards

What happens to the blood spot card after testing?

- DSHS keeps the blood spot cards in a secure place for up to two years. By Texas law (Health & Safety Code Sec. 33.018(b)-(c)), the blood spots may be used during that time. Uses include:
  - DSHS and external quality assurance to make sure tests, equipment, and supplies are working right
  - Developing new tests; and/or
  - DSHS studies of diseases that affect public health.
- If you give your OK, your baby's blood spot cards will be stored for up to 25 years, and they may be used for public health research outside of DSHS.

Please read below. Then you can decide what you would like DSHS to do with your baby's blood spot card when the Newborn Screening tests are finished.

- **If you check the 'OK' box AND sign this form:**
  - All of your baby's blood spot cards will be kept safe and secure for up to 25 years.
  - The blood spot cards may be used for public health research. The research may take place outside of DSHS. This research would study public health problems like cancer, birth defects, or other diseases.
  - You can change your mind at any time. Call DSHS (see number below) for details.
- **If you check the 'NO' box OR do not sign OR do not fill out OR do not return this form:**
  - The Newborn Screening tests will still be done as required by Texas law.
  - Your baby's blood spot cards will be kept safe and secure. They will be destroyed within two years.
  - The blood spot cards will NOT be used for public health research outside DSHS.

Can information about me or my child be released without my OK? No matter your choice on this form, no information that identifies you or your child can be released outside DSHS without your additional written OK. There are a few exceptions, as provided by law.

I have already sent this decision form. Do I need to send it again? NO. One form applies to all of your baby's newborn screening blood spot cards.

More information: Call 1(888) 963-7111 ext. 7333 or visit the web site: www.dshs.state.tx.us/lab/newbornscreening.shtm

PARENT: Please read this form. Select an option. Sign and return.

1. FILL OUT the form below.

Specimen Form Serial Number (if available): _____ Baby's Date of Birth: _____

Baby's First and Last Name: _____

Mother's First and Last Name: _____

Parent Phone Number: _____

2. CHECK one box only and SIGN below.

☐ 'OK' I give my **OK** for my baby's blood spot cards to be kept by DSHS after the Newborn Screen tests are complete. The de-identified blood spots may be used for public health research outside of DSHS.

☐ 'NO' I do **NOT** want my baby's blood spot cards to be used for any research outside of DSHS. I understand the blood spot cards will be destroyed within 2 years.

_____ _____

(Parent Signature) *(Date)*

3. RETURN this form to hospital or doctor's office staff. They will send it in with the blood spot cards. Or, you may **MAIL** it to:

Texas Department of State Health Services (DSHS)
Newborn Screening Laboratory, MC 1947
PO Box 149341 Austin, Texas 78714-9341