



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:

Breast/Bottle

Table food/Gerber _____ jars per day

Formula/Cow's Milk/Other _____ oz per day

Children/Teens

Healthy diet

Little junk Food

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

Has monthly period Yes No

Age of first period: _____ Years

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	<input type="checkbox"/>	<input type="checkbox"/>	Does your baby get quiet for a moment when you talk to him/her?
	<input type="checkbox"/>	<input type="checkbox"/>	Does your baby act startled or stop moving for a moment when there are sudden loud noises?
4 to 6 months	<input type="checkbox"/>	<input type="checkbox"/>	Does your baby turn his/her eyes or head to the sound of your voice if he/she cannot see you?
	<input type="checkbox"/>	<input type="checkbox"/>	Does your baby smile or stop crying when you or someone else he/she knows speaks?
7 to 9 months	<input type="checkbox"/>	<input type="checkbox"/>	Does your baby stop and pay attention when you say "no" or call his/her name?
	<input type="checkbox"/>	<input type="checkbox"/>	Does your baby move his/her head around to try and find out where a new sound is coming from?
	<input type="checkbox"/>	<input type="checkbox"/>	Does your baby make strings of sounds ("ba ba ba, da da da")?
10 to 15 months	<input type="checkbox"/>	<input type="checkbox"/>	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)?
	<input type="checkbox"/>	<input type="checkbox"/>	Does your baby point to familiar objects if you ask ("dog," "light")?
16 to 24 months	<input type="checkbox"/>	<input type="checkbox"/>	Does your child use his/her voice most of the time to get what he/she wants or to communicate with you?
	<input type="checkbox"/>	<input type="checkbox"/>	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	<input type="checkbox"/>	<input type="checkbox"/>	Does your child answer different kinds of questions ("When...", "Who...", "What...")?
	<input type="checkbox"/>	<input type="checkbox"/>	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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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.

Lead Risk Questionnaire

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?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does your child live in or visit a home, day-care or other building with ongoing repairs or remodeling?	<input type="checkbox"/>	<input type="checkbox"/>
3. Does your child eat or chew on non-food things like paint chips or dirt?	<input type="checkbox"/>	<input type="checkbox"/>
4. Does your child have a family member or friend who has or did have an elevated blood lead level?	<input type="checkbox"/>	<input type="checkbox"/>
5. Is your child a newly arrived refugee or foreign adoptee?	<input type="checkbox"/>	<input type="checkbox"/>
6. Does your child come in contact with an adult whose job or hobby involves lead exposure? <i>Examples</i> <ul style="list-style-type: none"> • 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 	<input type="checkbox"/>	<input type="checkbox"/>
7. Does your family use products from other countries such as pottery, health remedies, spices, or food? <i>Examples</i> <ul style="list-style-type: none"> • Traditional medicines such as Ayurvedic, greta, azarcón, alarcón, alcoh, 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. 	<input type="checkbox"/>	<input type="checkbox"/>

Test Immediately