

Parent / Guardian Questionnaire (1-2 year old)

Pediatric Specialists of the Northwest

Child's name: _____ Date of birth: _____ Date completed: _____

Your name: _____ Relation to child: _____

Check, circle, or complete all of which apply to your child

DAILY ACTIVITY and ROUTINE	NUTRITION and BOWEL HABITS
Childcare or Daycare <input type="checkbox"/> Yes <input type="checkbox"/> No	Daily intake:
I read to my child _____ days/week	Milk _____ oz / day
My child:	Dairy (yogurt, cheese, other) _____ servings / day
Gets _____ naps / day for a total of _____ hrs / day	Meat, poultry, fish, eggs & nuts _____ servings / day
Goes to bed inconsistently / consistently at _____ pm	Vegetables _____ servings / day
Gets _____ hours of sleep <i>on average</i> each night	Fruits _____ servings / day
Screen time (i.e. TV, computer) _____ hrs / day	Bread, cereal, rice & pasta _____ servings / day
Playtime _____ hrs / day	Fluoridated water <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
	Supplement: <input type="checkbox"/> vitamin <input type="checkbox"/> iron <input type="checkbox"/> Other _____
	Soda or pop _____ oz / day Juice _____ oz / day
	Fast food _____ times / week Junk food _____ times / day
	Concerns about bowel movements / urination <input type="checkbox"/> No <input type="checkbox"/> Yes

SOCIAL HISTORY
In the past year, have there been any changes or challenges in your family?
<input type="checkbox"/> Marriage <input type="checkbox"/> Loss of job <input type="checkbox"/> Births
<input type="checkbox"/> Separation <input type="checkbox"/> Move to a new neighborhood <input type="checkbox"/> Serious illness
<input type="checkbox"/> Divorce <input type="checkbox"/> Deaths
<input type="checkbox"/> Other: _____
<input type="checkbox"/> No interval changes
Does your child live with or spend time with anyone who uses tobacco or smokes? <input type="checkbox"/> No <input type="checkbox"/> Yes
FAMILY HISTORY
Have you or any of your child's relatives developed new medical problems since your last visit? <input type="checkbox"/> No <input type="checkbox"/> Yes

Check all that apply

HOW WOULD YOU BEST DESCRIBE YOUR CHILD
<input type="checkbox"/> Happy <input type="checkbox"/> Friendly <input type="checkbox"/> Quiet, Timid <input type="checkbox"/> Pays attention <input type="checkbox"/> Poor self-control
<input type="checkbox"/> Active <input type="checkbox"/> Sad <input type="checkbox"/> Cries easily <input type="checkbox"/> Hyperactive <input type="checkbox"/> Initiates physical fight
<input type="checkbox"/> Impulsive <input type="checkbox"/> Tired, Fatigue <input type="checkbox"/> Fears new situations <input type="checkbox"/> Separation anxiety
<input type="checkbox"/> Speech delay <input type="checkbox"/> Sleep problems <input type="checkbox"/> Stereotypic habit
<input type="checkbox"/> Social communication delay <input type="checkbox"/> Temper tantrums <input type="checkbox"/> Nail biting, thumb sucking, hair pulling
<input type="checkbox"/> Other concern: _____ <input type="checkbox"/> Head banging, body rocking

Reviewed and discussed by _____, MD/DO Date: _____

Parent / Guardian Questionnaire (1-2 year old)

Pediatric Specialists of the Northwest

Child's name: _____ Date of birth: _____ Date completed: _____

Your name: _____ Relation to child: _____

Lead Risk Assessment – Circle the appropriate response

1. Is this child eligible for or enrolled in Medicaid, Head Start, All Kids or WIC?	YES	NO	DON'T KNOW
2. Does this child have a sibling with a blood lead level of 10 mcg/dL or higher?	YES	NO	DON'T KNOW
3. Does this child live in or regularly visit a home built before 1978?	YES	NO	DON'T KNOW
4. In the past year, has this child been exposed to repairs, repainting or renovation of a home built before 1978?	YES	NO	DON'T KNOW
5. Is this child a refugee or an adoptee from any foreign country?	YES	NO	DON'T KNOW
6. Has this child ever been to Mexico, Central or South America, Asian countries (i.e. China or India), or any country where exposure to lead from certain items could have occurred (for example, cosmetics, home remedies, folk medicines or glazed pottery)?	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 or repair, bridge construction, plumbing, furniture refinishing, or work with automobile batteries or radiators, lead solder, leaded glass, lead shots, bullets or lead fishing sinkers)?	YES	NO	DON'T KNOW
8. At any time, has this child lived near a factory where lead is used (for example, a lead smelter or a paint factory)?	YES	NO	DON'T KNOW
9. Does this child reside in a high-risk zip code area? (see attached table of zip codes)	YES	NO	DON'T KNOW

Tuberculosis Assessment – Circle the appropriate response

1. Was your child born in a country/continent at high risk for tuberculosis?	YES	NO	DON'T KNOW
2. Has your child traveled for longer than 1 week to Africa, Asia, Latin America, or Eastern Europe?	YES	NO	DON'T KNOW
3. Has a family member or contact had tuberculosis or a positive tuberculin skin test?	YES	NO	DON'T KNOW
4. Does your child spend any time with anyone who has been in jail, uses illegal drugs, or has HIV?	YES	NO	DON'T KNOW

Additional Questions and Concerns (i.e. development, learning, behavior, etc...)

1)

2)

3)

4)

5)

Reviewed and discussed by _____, MD/DO Date: _____

**Illinois Department of Public Health
High Risk Zip Codes for Pediatric Lead Assessment
by County**

County	Zip Code	County	Zip Code
Boone	61038	DeKalb	60111
			60129
Cook	All Chicago zip codes		60146
	60043		60550
	60104	DuPage	60519
	60153		
	60201	Kane	60120
	60202		60505
	60301		
	60302	Kendall	None
	60304		
	60305	Lake	60040
	60402		
	60406	McHenry	60034
	60456		
	60501	Will	60432
	60513		60433
	60534		60436
	60546		
	60804		