9mo -10 year Visit

Today's Date: ___/___/___

Patient Name: _____ Date of Birth: ___/___/___

Patient Name: _____ Date of Birth: ___/___/___

Lead Assessment

Respond to the following questions:	**Yes****	**No**
1. Was your child's daycare/preschool/baby-sitter's house built before 1978?	◯	◯
2. Does your house have peeling or chipping paint?	◯	◯
3. Does your home's plumbing have lead or copper pipes with lead solder joints?	◯	◯
4. Do you use dishes and cups that come from outside the USA which might have a lead glaze?	◯	◯
5. In the past year, has this child been exposed to repairs, repainting, or a renovation of a home built before 1978?	◯	◯
6. Does your child have a sibling or playmate that has had an elevated lead level? (>5 mcg/dL)	◯	◯
7. Is your child a refugee or an adoptee from a foreign country?	◯	◯
8. Has your 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?	◯	◯
9. Does your child live with or frequently come in contact with someone who has a job or a hobby that may involve lead (i.e., construction, welding, pottery, jewelry making, work with sauntering materials, work with automobile batteries/radiators, leaded glass, lead shots, bullets, or lead fishing sinkers)?	◯	◯
10. At any time, has your child lived near a factory where lead is used (for example, lead smelter, paint factory, battery recycle plant, or any other industry where lead might be released)?	◯	◯
11. Does your child live near a heavily traveled major highway where soil and dust may be contaminated with lead?	◯	◯
12. Does your child receive medicines such as *greta, azarcon, kohl, or pay-loo-ah*?	◯	◯

A blood lead test should be performed on children with any "Yes" response, as well as, performed routinely at 12 mo. and 24 mo. per Georgia state requirements*

TB Exposure Assessment

Respond to the following questions:	**Yes***	**No**
1. Has your child traveled to Eastern Europe, Asia, Africa, Central or South American since last WCC for period > 1 week?	◯	◯
2. Does your child have frequent hospital visits?	◯	◯
3. Does your child have frequent prison visits?	◯	◯
4. Does your child have frequent homeless shelter visits?	◯	◯
5. Does your child have frequent nursing home visits?	◯	◯
6. Does your child have contact with someone infected with TB?	◯	◯
7. Does your child have or come in contact with a person who has HIV?	◯	◯
8. Was your child born outside the US?	◯	◯
9. Does your child have contact with drug users or migrant workers?	◯	◯
10. Does your child have a known immune disorder?	◯	◯

if yes, your child may need a PPD placed or IGRA blood test performed to rule out infection with Tuberculosis*

Cholesterol Assessment

FAMILY HISTORY	Yes*	No
1. Is there a parent/grandparent/Aunt or Uncle/sibling with history of heart attack, treated angina, CABG/stent/angioplasty, stroke, sudden cardiac death in Male </= 55 yrs or female </= 65 yrs?	○	○
2. Does a parent have Total cholesterol > 240 mg/dL or history of dyslipidemia?	○	○

PATIENT'S PERSONAL HISTORY		
1. Does patient have a history of Diabetes, High BP, BMI >/= 85% or use tobacco?	○	○
2. Does patient have chronic kidney disease, kidney or heart transplant, Kawasaki's disease, autoimmune illness, HIV or nephrotic syndrome?	○	○

If yes, then your child may need a fasting lipid panel drawn (if not done previously) or if prior results were abnormal*

Live Vaccine Assessment

Respond to the following questions:	Yes**	No
1. Is the child sick today?	○	○
2. Has the child ever had a life threatening allergic reaction to neomycin or a component of a live vaccine, including egg?	○	○
3. Does the child have chronic heart disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, DM or anemia?	○	○
4. Does the child have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long-term treatment with drugs such as high-dose steroids, or cancer treatment with radiation or drugs?	○	○
5. Is the child receiving antiviral medications?	○	○
6. Is the child receiving aspirin therapy or aspirin-containing therapy?	○	○
7. Has the child ever had Guillain-Barré syndrome?	○	○
8. Does the child live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (e.g., an isolation room of a bone marrow transplant unit)?	○	○
9. Has the child received any other vaccinations in the past 4 weeks?	○	○

****These questions help us determine if there is any reason we should not give your child a live vaccine today****

___YES ___ NO** Do you use **Fluoridated** water (treated tap (city/county), filtered through refrigerator, or bottled water)?

___YES ___ NO** Has your child **seen a dentist** in the past 6 – 12 months?

___YES ___ NO Do you have concerns about your child's eyes or their **ability to see**?

___YES ___ NO Do you have any concerns about your child's **ability to hear**?

___YES ___ NO** Does your child's **diet contain Iron- rich foods** such as meat, eggs, iron-fortified cereal and beans?