

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Today's Date: \_\_\_/\_\_\_/\_\_\_

**2, 4, and 6 Month Visits**

**Live Vaccine Assessment**

<b>Respond to the following questions:</b>	<b>Yes</b>	<b>No</b>
1. Is the child sick today?	<input type="radio"/>	<input type="radio"/>
2. Has the child ever had a life threatening allergic reaction to neomycin or a component of a live vaccine, including egg?	<input type="radio"/>	<input type="radio"/>
3. Does the child have chronic heart disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, DM or anemia?	<input type="radio"/>	<input type="radio"/>
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?	<input type="radio"/>	<input type="radio"/>
5. Is the child receiving antiviral medications?	<input type="radio"/>	<input type="radio"/>
6. Is the child receiving aspirin therapy or aspirin-containing therapy?	<input type="radio"/>	<input type="radio"/>
7. Has the child ever had Guillain-Barré syndrome?	<input type="radio"/>	<input type="radio"/>
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)?	<input type="radio"/>	<input type="radio"/>
9. Has the child received any other vaccinations in the past 4 weeks?	<input type="radio"/>	<input type="radio"/>

**\*\*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) or bottled water)?

\_\_\_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 Is your child on low iron formula?

**\*\*This response may require referral to a specialist or further evaluation/treatment recommendations\*\***

**TB Exposure Assessment**

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

**\*if yes and PPD not done previously in past year, recommendation is to have a PPD (TB screening test)**

**\*\*Please Complete Both Sides of Page\*\***

## Lead Assessment

<b>Respond to the following questions:</b>	<b>Yes</b>	<b>No</b>
1. Was your child's daycare/preschool/babysitter's house built before 1978?	<input type="radio"/>	<input type="radio"/>
2. Does your house have peeling or chipping paint?	<input type="radio"/>	<input type="radio"/>
3. Does your home's plumbing have lead or copper pipes with lead solder joints?	<input type="radio"/>	<input type="radio"/>
4. Do you use dishes and cups that come from outside the USA which might have a lead glaze?	<input type="radio"/>	<input type="radio"/>
5. In the past year, has this child been exposed to repairs, repainting, or a renovation of a home built before 1978?	<input type="radio"/>	<input type="radio"/>
6. Does your child have a sibling or playmate that has had an elevated lead level? (>5 mcg/dL)	<input type="radio"/>	<input type="radio"/>
7. Is your child a refugee or an adoptee from a foreign country?	<input type="radio"/>	<input type="radio"/>
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?	<input type="radio"/>	<input type="radio"/>
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)?	<input type="radio"/>	<input type="radio"/>
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)?	<input type="radio"/>	<input type="radio"/>
11. Does your child live near a heavily traveled major highway where soil and dust may be contaminated with lead?	<input type="radio"/>	<input type="radio"/>
12. Does your child receive medicines such as <i>greta</i> , <i>azarcon</i> , <i>kohl</i> , or <i>pay-loo-ah</i> ?	<input type="radio"/>	<input type="radio"/>

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

## Postnatal Depression Screen (10+)

### **IN THE PAST 7 DAYS,**

- |   |  |
|---|--|
| <p>1. I have been able to laugh and see the funny side of things</p> <ul style="list-style-type: none"> <li><input type="radio"/> As much as I always could</li> <li><input type="radio"/> Not quite so much now</li> <li><input type="radio"/> Definitely not so much now</li> <li><input type="radio"/> Not at all</li> </ul> <p>2. I have looked forward with enjoyment to things</p> <ul style="list-style-type: none"> <li><input type="radio"/> As much as I ever did</li> <li><input type="radio"/> Rather less than I used to</li> <li><input type="radio"/> Definitely less than I used to</li> <li><input type="radio"/> Hardly at all</li> </ul> <p>3. I have blamed myself unnecessarily when things went wrong</p> <ul style="list-style-type: none"> <li><input type="radio"/> No, never</li> <li><input type="radio"/> Not very often</li> <li><input type="radio"/> Yes, some of the time</li> <li><input type="radio"/> Yes, most of the time</li> </ul> <p>4. I have been anxious or worried for no good reason</p> <ul style="list-style-type: none"> <li><input type="radio"/> No, not at all</li> <li><input type="radio"/> Hardly ever</li> <li><input type="radio"/> Yes, sometimes</li> <li><input type="radio"/> Yes, very often</li> </ul> <p>5. I have felt scared or panicky for no very good reason</p> <ul style="list-style-type: none"> <li><input type="radio"/> No, not at all</li> <li><input type="radio"/> No, not much</li> <li><input type="radio"/> Yes, sometimes</li> <li><input type="radio"/> Yes, quite a lot</li> </ul> | <p>6. Things have been getting on top of me</p> <ul style="list-style-type: none"> <li><input type="radio"/> No, I have been coping as well as ever</li> <li><input type="radio"/> No, most of the time I have coped quite well</li> <li><input type="radio"/> Yes, sometimes I haven't been coping as well as usual</li> <li><input type="radio"/> Yes, most of the time I haven't been able to cope at all</li> </ul> <p>7. I have been so unhappy that I have had difficulty sleeping</p> <ul style="list-style-type: none"> <li><input type="radio"/> No, not at all</li> <li><input type="radio"/> Not very often</li> <li><input type="radio"/> Yes, sometimes</li> <li><input type="radio"/> Yes, most of the time</li> </ul> <p>8. I have felt sad or miserable</p> <ul style="list-style-type: none"> <li><input type="radio"/> No, not at all</li> <li><input type="radio"/> Not very often</li> <li><input type="radio"/> Yes, quite often</li> <li><input type="radio"/> Yes, most of the time</li> </ul> <p>9. I have been so unhappy that I have been crying</p> <ul style="list-style-type: none"> <li><input type="radio"/> No, never</li> <li><input type="radio"/> Only occasionally</li> <li><input type="radio"/> Yes, quite often</li> <li><input type="radio"/> Yes, most of the time</li> </ul> <p>10. The thought of harming myself has occurred to me</p> <ul style="list-style-type: none"> <li><input type="radio"/> Never</li> <li><input type="radio"/> Hardly ever</li> <li><input type="radio"/> Sometimes</li> <li><input type="radio"/> Yes, quite often</li> </ul> |
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**\*\*Please Complete Both Sides of Page\*\***