Gwendolyn Delaney, MD　**Soraya Lim, MD**　**Belinda Miller Topa, MD**　**Gargi Shikhare, MD**

Patient Name: ______________________ Date of Birth: ____/____/____ Today's Date: ____/____/____
Patient Name: ______________________ Date of Birth: ____/____/____ Today's Date: ____/____/____

2, 4, and 6 Month Visits

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) 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

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

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

Lead Assessment

Respond to the following questions:	Yes	No
1. Was your child's daycare/preschool/babysitter'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 perform routinely at 12 mo. and 24 mo. per Georgia state requirements*

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Revised 02/2018

Postnatal Depression Screen (10+)

IN THE PAST 7 DAYS…

1. I have been able to laugh and see the funny side of things
   - ○ As much as I always could
   - ○ Not quite so much now
   - ○ Definitely not so much now
   - ○ Not at all
2. I have looked forward with enjoyment to things
   - ○ As much as I ever did
   - ○ Rather less than I used to
   - ○ Definitely less than I used to
   - ○ Hardly at all
3. I have blamed myself unnecessarily when things went wrong
   - ○ No, never
   - ○ Not very often
   - ○ Yes, some of the time
   - ○ Yes, most of the time
4. I have been anxious or worried for no good reason
   - ○ No, not at all
   - ○ Hardly ever
   - ○ Yes, sometimes
   - ○ Yes, very often
5. I have felt scared or panicky for no very good reason
   - ○ No, not at all
   - ○ No, not much
   - ○ Yes, sometimes
   - ○ Yes, quite a lot
6. Things have been getting on top of me
   - ○ No, I have been coping as well as ever
   - ○ No, most of the time I have coped quite well
   - ○ Yes, sometimes I haven't been coping as well as usual
   - ○ Yes, most of the time I haven't been able to cope at all
7. I have been so unhappy that I have had difficulty sleeping
   - ○ No, not at all
   - ○ Not very often
   - ○ Yes, sometimes
   - ○ Yes, most of the time
8. I have felt sad or miserable
   - ○ No, not at all
   - ○ Not very often
   - ○ Yes, quite often
   - ○ Yes, most of the time
9. I have been so unhappy that I have been crying
   - ○ No, never
   - ○ Only occasionally
   - ○ Yes, quite often
   - ○ Yes, most of the time
10. The thought of harming myself has occurred to me
    - ○ Never
    - ○ Hardly ever
    - ○ Sometimes
    - ○ Yes, quite often

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