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

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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 <i>greta</i> , <i>azarcon</i> , <i>kohl</i> , or <i>pay-loo-ah</i> ?	☐	☐

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*

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

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