Date of Service: _____ **Acct #:** _____
Patient Name: _____ **DOB:** _____

Medical Screening Questionnaire

Does your child have a sibling or playmate that has or has had lead poisoning?	YES	NO	UNSURE
Does your child live in or regularly visit a house or child care facility built before 1978 that is being or has been renovated in the last 6 months?	YES	NO	UNSURE
Does your child live in or regularly visit a house or child care facility built before 1950?	YES	NO	UNSURE
Does your child chew on or eat non-food items like paint chips or dirt?	YES	NO	UNSURE
Was your child born in a country at high risk for tuberculosis?	YES	NO	UNSURE
Has your child traveled for longer than a week to a country at high risk for tuberculosis?	YES	NO	UNSURE
Has a family member or contact had tuberculosis or a positive tuberculin test?	YES	NO	UNSURE
Is your child infected with HIV or have any conditions that lower the immune system?	YES	NO	UNSURE
Has your child been exposed to anyone who is in jail, has HIV, is homeless, or uses illegal drugs	YES	NO	UNSURE
Has a doctor ever ordered a test for your child's heart?	YES	NO	UNSURE
Has your child ever had discomfort, pain, or pressure in his chest during exercise?	YES	NO	UNSURE
Has your child ever had extreme shortness of breath, or extreme fatigue, during exercise (different from other children)?	YES	NO	UNSURE
Has your child fainted or passed out DURING or AFTER exercise, emotion, or startle?	YES	NO	UNSURE
Are there any family members who had a sudden, unexpected, unexplained death before age 50? (Including SIDS, car accident, drowning, others) or near drowning? If yes, what? _____	YES	NO	UNSURE
Does your child have any relatives who have had a stroke or "heart problem" before age 55? If yes, what? _____	YES	NO	UNSURE
Does your child have a parent with elevated blood cholesterol (240 mg/dL or higher) or who is taking cholesterol medication?	YES	NO	UNSURE
Do you have any concerns about how your child sees?	YES	NO	UNSURE
Do you have any concerns about how your child hears?	YES	NO	UNSURE
Do you have any concerns about your child's speech?	YES	NO	UNSURE
Does anyone in your household smoke?	YES	NO	UNSURE
Do you have city or well water?	CITY		WELL
Does your child have a dentist? If yes, who do they see? _____	YES	NO	
Has your child visited the dentist in the last 6 months?	YES	NO	
Has mom had any cavities in the past 1 to 2 years?	YES	NO	

For Patients 11 years and older

Do you wear a seat belt all the time? YES NO
Do you or have you ever ridden in a car driven by someone who was using drugs or alcohol? YES NO
Do you or have you ever smoked cigarettes (regular or electronic)/VAPE/JUUL? YES NO
Do you or have you ever used any kind of drugs including synthetic marijuana (aka: spice) or alcohol? YES NO

Over the past 2 weeks, have you had little interest or pleasure in doing things? **YES** or N**O**
If yes, how many days? (please circle your answer) several days, more than half of the days, almost everyday

Over the past 2 weeks, have you been feeling down, depressed, or hopeless? **YES** or **NO**
If yes, how many days? (please circle your answer) several days, more than half of the days, almost everyday

Are you or have you ever been sexually active? YES NO