

MARYLAND HEALTHY KIDS PROGRAM

Preventive Screening Questionnaire

Patient Name: _____

Date of Birth: _____

Date: _____

ANEMIA SCREENING

(Starting at 11 years of age and annually thereafter)

1. Does your diet include iron-rich foods such as meat, eggs, fortified cereals, or beans?
 Yes No
2. Have you ever been diagnosed with iron-deficiency anemia?
 Yes No
3. (Females only) Do you have excessive menstrual bleeding or other blood loss?
 Yes No
4. (Females only) Does your period last more than 5 days?
 Yes No

LEAD RISK ASSESSMENT

(From 6 months through 6 years)

1. Has your child lived or spent time in a house or apartment built before 1978 (including daycare, babysitter's house, or relatives)?
 Yes No
2. Is anyone in the home being treated or followed for lead poisoning?
 Yes No
3. Are there any current renovations or peeling paint in a home or place your child regularly visits?
 Yes No
4. Does your child lick, eat, or chew things that are not food (paint, dirt, railings, furniture, old toys, etc.)?
 Yes No
5. Does anyone in the family work in an occupation or hobby where lead exposure may occur (mechanic, ceramics, commercial painting, etc.)?
 Yes No

TUBERCULOSIS RISK ASSESSMENT

(From 1 month of age and annually thereafter)

1. Has your child been exposed to someone with tuberculosis or a positive tuberculin skin test?
 Yes No
2. Was your child or anyone in the household born in a high-risk country (countries other than the United States, Canada, Australia, New Zealand, or Northern/Western Europe)?
 Yes No
3. Has your child traveled (and had contact with local populations) in a high-risk country for more than 1 week?
 Yes No
4. Does your child have daily contact with adults at high risk for TB (for example, HIV positive, homeless, incarcerated, or illicit drug users)?
 Yes No
5. Does your child have HIV infection?
 Yes No

(A "Yes" or "Don't know" answer to any question indicates a positive risk.)

RISK ASSESSMENT

Reviewer _____

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HEART DISEASE / CHOLESTEROL RISK ASSESSMENT

(2 to 20 years of age)

1. Has a parent or grandparent younger than 55 had a heart attack, heart surgery, angina, or sudden cardiac death?
 Yes No
2. Has the child's mother or father been diagnosed with high cholesterol (240 mg/dL or higher)?
 Yes No
3. Is the child/adolescent overweight (BMI greater than 85th percentile)?
 Yes No

Personal history of the child/adolescent:

1. Smoking
 Yes No
2. Lack of physical activity
 Yes No
3. High blood pressure
 Yes No
4. High cholesterol
 Yes No
5. Diabetes mellitus
 Yes No

STI / HIV RISK ASSESSMENT

(11 to 20 years of age)

1. Have you received a blood transfusion or do you have hemophilia?
 Yes No
2. Have you ever been sexually abused or physically attacked?
 Yes No
3. Have you ever been diagnosed with a sexually transmitted disease?
 Yes No
4. Is there a history of IV drug use by you, your sexual partner, or your biological mother during pregnancy?
 Yes No
5. If sexually active, have you had unprotected sex (with same-sex or opposite-sex partner)?
 Yes No
6. If sexually active, have you had more than one sexual partner?
 Yes No
7. Do you have tattoos or body piercings (ears, navel, etc.), including those performed by friends?
 Yes No

(A "Yes" or "Don't know" answer to any question indicates a positive risk.)

Reviewer _____