# Patient History Form - Newborn to 5 years

**Patient Name**_____ **DOB**_____

**Sex M F History given by**_____ **Date**_____

**Patient Information:**

**Are immunizations up to date? Yes or No**

**Birth History**: Was infant born early or late? Yes or No

If yes, how many weeks? _____

What was infants birth weight? _____

Did your child have any respiratory problems, jaundice, or other problems at birth?

_____

**Acute Illness / Chronic Illness / Medical Issues:** List all past and present diagnoses

_____

_____

**Hospitalizations or ER Visits:** List any that have occurred since the last well check

_____

_____

**Surgeries:** List any that have occurred since the last well check

_____

**Allergies:** _____

**Medications**: name, dose, what is it given for?

_____

_____

**Social History**:

Who does the patient live with?

_____

If biological parents are separated or don't live in the same home as the patient, how often does the child visit the other home?

_____

Does your child have any pets in or outside of the home? Yes No

If yes, list pets: _____

Does anyone in the household smoke or vape? _____

Any recent travel since the last well check? Yes No Where? _____

**Family History - Please provide information for patient's parents, siblings and grandparents:**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Heart Problems/ Heart Attack | Y | N | Migraines/Headaches | Y | N | Allergies | Y | N |
| High Cholesterol | Y | N | ADHD/ADD | Y | N | Eczema | Y | N |
| High Blood Pressure | Y | N | Diabetes | Y | N | Depression or Anxiety | Y | N |
| Asthma | Y | N | Thyroid Problems | Y | N | Obesity | Y | N |
| Stomach Problems | Y | N | Bleeding or Clotting Problems | Y | N | Alcoholism | Y | N |
| Kidney/Bladder Problems | Y | N | Anemia | Y | N | Drug Abuse | Y | N |
| Seizures | Y | N | Arthritis | Y | N | Cancer | Y | N |

# Questions About Your Child and Tuberculosis (TB)

Child's Name _____ Date of Birth _____

Your Name _____

Today's Date _____

Texas Health Steps

We need your help to find out if your child has been exposed to the disease tuberculosis, also known as TB.

TB is caused by germs. It is usually spread to another person by coughing or sneezing. A person can have TB germs in their body but not have active TB disease. TB can be prevented and treated. Your answers to the questions below will let us know if your child might have been exposed to TB. If your answers show your child might have picked up the TB germs, we will want to give him or her a TB skin test. The skin test is not a vaccination. It will not prevent TB. It will only let us know if your child has the TB germs.

| Check the box that matches your answer: | Yes | No | Do Not Know |
|---|---|---|---|
| 1. Has your child been tested for TB?<br>If yes, when? Please tell us the date _____ | | | |
| 2. Have you ever been told that your child had a positive TB skin test (TST)?<br>If yes, when? Please tell us the date _____ | | | |
| 3. TB can cause fever that can last days or weeks. It can cause weight loss, a bad cough (lasting over two weeks), or coughing up blood. | | | |
| Has your child been around anyone with any of these problems? | | | |
| Has your child been around anyone sick with TB? | | | |
| Has your child ever had any of these problems or do they have them now? | | | |
| 4. Was your child born in another part of the world like Mexico or Latin America, the Caribbean, Africa, Eastern Europe, or Asia? | | | |
| 5. Has your child been to Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe, or Asia for more than 3 weeks?<br>Which country or countries did your child visit? _____ | | | |
| 6. Do you know if your child has spent more than 3 weeks with anyone who: | | | |
| Uses needles for drug use? | | | |
| Has AIDS? | | | |
| Was or is in jail or prison? | | | |
| Has just come to the United States from another country? | | | |

FOR THE PROVIDER:

If the prior test was negative and the answer to #4 is yes, the child does not need a repeat skin test.
If the prior test was negative and occurred at least 8 weeks after the situation described in #3a, 3b, 5, or 6, the child does not need a repeat skin test.
If the prior test was positive, the child does not need a repeat skin test; but a positive answer to #3c would indicate a chest x-ray as soon as possible.

PPD administered Yes___ No___
If yes,
Date administered ____/____/____ Date read ____/____/____ PPD response_____ mm

PPD provider _____ _____
Signature Printed Name
If chest x-ray done, date and results

_____

Provider phone number_____City_____County_____

If positive, referral to local/regional health department/specialist? Yes___ No___
If yes, name of health dept/specialist _____

Contact your local or regional health department if assistance is needed.

TEXAS Department of State Health Services

# Lead Risk Questionnaire

Form Pb-110

**Purpose:** To identify children who need to be tested for lead exposure.

## Instructions

- If **Yes or Don't Know**, test the child immediately.
- You may administer a blood lead test instead of using this questionnaire.
- For more information, contact the Texas Childhood Lead Poisoning Prevention Program at: 1-800-588-1248.

**Patient's Name:** _____ **DOB:** _____ **Medicaid #:** _____

**Provider's Name:** _____ **Administered by:** _____ **Date** _____

## Questions

| | Yes or Don't Know | No |
|---|---|---|
| 1. Does your child live in or visit a home, day-care or other building built before 1978? | ☐ | ☐ |
| 2. Does your child live in or visit a home, day-care or other building with ongoing repairs or remodeling? | ☐ | ☐ |
| 3. Does your child eat or chew on non-food things like paint chips or dirt? | ☐ | ☐ |
| 4. Does your child have a family member or friend who has or did have an elevated blood lead level? | ☐ | ☐ |
| 5. Is your child a newly arrived refugee or foreign adoptee? | ☐ | ☐ |
| 6. Does your child come in contact with an adult whose job or hobby involves lead exposure? | ☐ | ☐ |

*Examples*

- House construction or repair
- Battery manufacturing or repair
- Burning lead-painted wood
- Automotive repair shop or junk yard
- Going to a firing range or reloading bullets
- Chemical preparation
- Valve and pipe fittings
- Brass/copper foundry
- Refinishing furniture
- Making fishing weights
- Radiator repair
- Pottery making
- Lead smelting
- Welding

| | | |
|---|---|---|
| 7. Does your family use products from other countries such as pottery, health remedies, spices, or food? | ☐ | ☐ |

*Examples*

- Traditional medicines such as Ayurvedic, greta, azarcón, alarcón, alkohl, bali goli, coral, ghasard, liga, pay-loo-ah, and rueda
- Cosmetics such as kohl, surma, and sindor
- Imported or glazed pottery, imported candy, and imported nutritional pills other than vitamins.
- Foods canned or packaged outside the U.S.

Test Immediately

## Fax this form to 512-776-7699 or mail to the address below.

Texas Childhood Lead Poisoning Prevention Program • Texas Department of State Health Services
PO BOX 149347 • Austin, TX 78714-9347 • 1-800-588-1248 • www.dshs.state.tx.us/lead

Revised December 22, 2011

# PEDS RESPONSE FORM

Provider

*Child's Name* _____ *Parent's Name* _____

*Child's Birthday* _____ *Child's Age* _____ *Today's Date* _____

*Please list any concerns about your child's learning, development, and behavior.*

*Do you have any concerns about how your child talks and makes speech sounds?*
*Circle one: No Yes A little COMMENTS:*

*Do you have any concerns about how your child understands what you say?*
*Circle one: No Yes A little COMMENTS:*

*Do you have any concerns about how your child uses his or her hands and fingers to do things?*
*Circle one: No Yes A little COMMENTS:*

*Do you have any concerns about how your child uses his or her arms and legs?*
*Circle one: No Yes A little COMMENTS:*

*Do you have any concerns about how your child behaves?*
*Circle one: No Yes A little COMMENTS:*

*Do you have any concerns about how your child gets along with others?*
*Circle one: No Yes A little COMMENTS:*

*Do you have any concerns about how your child is learning to do things for himself/herself?*
*Circle one: No Yes A little COMMENTS:*

*Do you have any concerns about how your child is learning preschool or school skills?*
*Circle one: No Yes A little COMMENTS:*

*Please list any other concerns.*