CHILD'S FAMILY MEDICAL HISTORY (parents, grandparents, brothers, sisters, aunts, uncles, cousins)

CHECK ALL THAT APPLY **CHILD'S NAME:** **DOB:**

☐ Headache	☐ High blood pressure	☐ Kidney disease, bladder, urinary tract disease
☐ Vision/Hearing problem (other than glasses)	☐ Scoliosis or curvature of the spine	☐ Unexplained infant or child death
☐ Mental retardation	☐ Cystic fibrosis	☐ AIDS/Immunodeficiency
☐ Mental illness	☐ Substance abuse	☐ Hepatitis
☐ Seizures, convulsions, epilepsy	☐ Tobacco use	☐ Cancer
☐ Sexually transmitted disease	☐ Disease of the blood	☐ Birth defects
☐ Bone joint disorders or congenital hip disease	☐ Allergies (food, drug, asthma, eczema)	☐ Heart attack or stroke or sudden unexplained death (under 50 years of age)
☐ Other significant history	☐ Diabetes	☐ High Cholesterol

(Please circle one)

Any problems or complications with birth or pregnancy?

Yes No
If so, please describe:

Child's birth weight: _____

Does the child receive any special services, public health nurse, counseling, special help at school?

Yes No
If so, please describe:

Any trouble with weight gain or loss?

Yes No
If so, please describe:

How many days has the child missed from school in the last Year due to:

Illness: Injury: Other:

DOES YOUR CHILD HAVE OR HAS YOUR CHILD HAD *(Please describe where applicable and add the date next to each):*

Chicken pox?

Any major illness/injuries/operations, hospitalizations?

Any reactions/allergies to immunizations or medicines?

Any learning or discipline problems?

Other stresses (i.e. birth of another child, death in family, Household moves, money problems, marital problems, etc) ***Please be specific***

Other concerns?

PEDIATRICS WEST
Lorelle Manion, M.D.
Megan E.G. Hambrook, M.D.

IS YOUR CHILD AT RISK FOR LEAD EXPOSURE?

CHILD'S NAME_____**DOB**_____

Is or does your child...

1. Live in or visit a house built before 1950, or has he/she ever in the past?
   _____ Yes _____ No _____ Don't know

2. Live in a house or regularly visit a house that has chipping, peeling or cracking paint on windowsills, in window wells, on walls, or on the outside of the building? (including day care, sitter's home, relative home, etc…)
   _____ Yes _____ No _____ Don't know

3. Live in or regularly visit a house built before 1978 that is being remodeled, painted, or repaired? (Recent, ongoing or planning in the near future)
   _____ Yes _____ No _____ Don't know

4. Put non-food items in his/her mouth? (Thumb, fingers, toys, paper, etc…)
   _____ Yes _____ No _____ Don't know

5. Have a brother, sister, cousin, or playmate who has lead poisoning?
   _____ Yes _____ No _____ Don't know

6. Lived with an adult whose job or hobby involves exposure to lead? (Includes car repairs, battery manufacturing, painting, construction or house remodeling)
   _____ Yes _____ No _____ Don't know

7. Enrolled in or eligible for Medicaid, Health Check, or WIC?
   _____ Yes _____ No _____ Don't know

Do you or anyone in your home…

8. Ever use home remedies from other countries? (Greta, Azarcon, Paylooah)
   _____ Yes _____ No _____ Don't know

9. Ever use cosmetics from other countries? (Kohl, surma)
   _____ Yes _____ No _____ Don't know

10. Ever cook or prepare foods in ceramic pots from other countries? (Bean pot)
    _____ Yes _____ No _____ Don't know

If you answered YES to any of these questions, discuss with the doctor about having child screened for lead.

Milwaukee Health Department
Childhood Lead Poisoning Prevention Program
225-LEAD (5323)

PEDIATRICS WEST
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TUBERCULOSIS (TB) SCREENING QUESTIONNAIRE

Patient _____ **DOB:** _____

	CIRCLE ONE:	
1. Is there a family history of TB?	Yes	No
2. Is your child or family from a nation with a high TB rate?	Yes	No
3. Has your family had contact with someone with HIV infection or AIDS?	Yes	No
4. Has your family had contact with someone who in the last 5 years has been in a correctional institution?	Yes	No
5. Does your child live in a neighborhood or community known to have high TB rates?	Yes	No
6. Does your family have any foster children/adopted children with an unknown medical history?	Yes	No