CHILD'S NAME (LAST, FIRST, MI)_____

SPONSOR'S SS# LAST 4 (last name if different than child)_____

CHILD'S BIRTHDATE_____

6 MONTH SCREENING QUESTIONNAIRE

Lead screening	
~Does your child live in or regularly visit a house or other location (day care center, preschool, friend's or babysitter's house) with PEELING or CHIPPING paint and which was built before 1978?	( ) yes ( ) no ( )don't know
~Does your child live in or regularly visit Mexico?	( ) yes ( ) no ( )don't know
~Does your child eat Mexican candy?	( ) yes ( ) no ( )don't know
~Does your child have a parent, brother, sister, housemate, or playmate who is being treated or followed for lead poisoning?	( ) yes ( ) no ( )don't know
~ Does your child live with someone whose job or hobby involves exposure to products containing lead (i.e. storage of batteries, valves and pipe fittings, plumbing fixtures, car parts or repair, leaded or stained glass, pottery, furniture refinishing, painting or soldering, work or recreational use of a gun, firing range, or lead shot in those guns)?	( ) yes ( ) no ( )don't know
~Has your child ever lived near an active lead smelter, battery recycling plant, or other industry likely to release lead?	( ) yes ( ) no ( )don't know
~Do you use home remedies or cosmetics containing lead (i.e. Azarcon, greta, pay-loo-ah, alkohl, kohl)?	( ) yes ( ) no ( )don't know
~Do you use imported or handmade dishes/containers to serve prepare, or store food or drink (i.e. lead smoldered can, Imported pottery, leaded crystal or glass, antique pewter)?	( ) yes ( ) no ( )don't know
Hearing Screening	
~ Do you have any concerns about your child's hearing?	( ) yes ( ) no
Vision Screening	
~Do you have any concerns about your child's vision?	( ) yes ( ) no
Dental screening	
~Does your child take a bottle of juice or milk to bed?	( ) yes ( ) no
~Does your child get his/her teeth brushed at least once per day?	( ) yes ( ) no
TB Screening	
~Has a family member or contact had tuberculosis disease?	( ) yes ( ) no
~Has a family member had a positive tuberculin skin test (+PPD)?	( ) yes ( ) no
~Was your child born in a high risk country (countries other than the US, Canada, Australia, New Zealand, or Western European countries? Name of country_____	( ) yes ( ) no
~Has your child traveled to a high-risk country for more than 1 week? Name of countries_____	( ) yes ( ) no
Domestic Violence Screening	
~Do you ever feel unsafe for yourself or your children in your home?	( ) yes ( ) no
~Has your child ever witnessed a frightening or violent experience at home?	( ) yes ( ) no
~Are you concerned that anyone has hurt you or your child physically or sexually?	( ) yes ( ) no
~Have you ever misled your family, friends, or doctors about bruises, cuts, or scratches?	( ) yes ( ) no

Please also complete the separate Post Partum Depression Screen.