

TB Questionnaire

Name of Child _____ Date of Birth _____

Organization administering questionnaire _____ Date _____

Tuberculosis (TB) is a disease caused by TB germs and is usually transmitted by an adult person with active TB lung disease. It is spread to another person by coughing or sneezing TB germs into the air. These germs may be breathed in by the child.

Adults who have active TB disease usually have many of the following symptoms: cough for more than two weeks duration, loss of appetite, weight loss of ten or more pounds over a short period of time, fever, chills and night sweats.

A person can have TB germs in his or her body but not have active TB disease (this is called latent TB infection or LTBI).

Tuberculosis is preventable and treatable. TB skin testing (often called the PPD or Mantoux test) is used to see if your child has been infected with TB germs. No vaccine is recommended for use in the United States to prevent tuberculosis. The skin test is not a vaccination against TB.

We need your help to find out if your child has been exposed to tuberculosis.

Place a mark in the appropriate box:	Yes	No	Don't Know
TB can cause fever of long duration, unexplained weight loss, a bad cough (lasting over two weeks), or coughing up blood. As far as you know: has your child been around anyone with any of these symptoms or problems? or has your child had any of these symptoms or problems? or has your child been around anyone sick with TB?			
Was your child born in Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia?			
Has your child traveled in the past year to Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia for longer than 3 weeks? If so, specify which country/countries? _____			
To your knowledge, has your child spent time (longer than 3 weeks) with anyone who is/has been an intravenous (IV) drug user, HIV-infected, in jail or prison or recently came to the United States from another country?			

Has your child been tested for TB? Yes___ (if yes, specify date ___/___/___) No___

Has your child ever had a positive TB skin test? Yes___ (if yes, specify date ___/___/___) No___

For school/healthcare provider use only

PPD administered Yes___ No___

If yes,
Date administered ___/___/___ Date read ___/___/___ Result of PPD test _____ mm response

Type of service provider (i.e. school, Health Steps, other clinics) _____

PPD provider _____
signature printed name

Provider phone number _____

City _____ County _____

If positive, referral to healthcare provider Yes___ No___

If yes, name of provider _____



The risk assessment questionnaire contains 6 questions that appear on page 2, and is designed to be administered to the parent by the healthcare provider. Questions are in English and Spanish to assist with Spanish speaking parents.

Instructions:

- This questionnaire may be used with any child, whether or not enrolled in Texas Health Steps.
- Medicaid requires a blood lead test for all Texas Health Steps patients at 12 months and 24 months. For children less than 6 years of age, complete a blood lead test at any first checkup after age 12 and 24 months if there is no evidence of a previous blood lead test.
- At any visit, you may choose to perform a blood lead test rather than use the risk assessment questionnaire.
- Refer to the table below for scheduling use of the risk assessment questionnaire.
- A “yes” or “don’t know” answer to any question on the risk assessment questionnaire indicates that a blood lead test should be administered.

Child's Age	Parent Questionnaire	Blood Lead Test
6 months	YES	
9 months	YES	
12 months		YES
15 months	YES	
18 months	YES	
24 months		YES
3, 4, 5, and 6 years	YES	



For more information, contact the Texas Childhood Lead Poisoning Prevention Program at:

1-800-588-1248

<http://www.dshs.state.tx.us/lead>

Fax completed form to 512-458-7699, or mail to the address below.

Healthcare Provider: For children less than 6 years of age, complete a blood lead test at any first checkup after age 12 and 24 months if there is no evidence of a previous blood lead test.

Patient's Name:	DOB:	Medicaid #:
Provider's Name:	Administered by:	Date:

Parent Questionnaire		Yes	Don't know	No	
1	Does your child live in or visit a home, daycare or other building built before 1978?				
2	Does your child live in or visit a home, daycare 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	Is your child exposed to any of the following (if YES, check all that apply):				
Contamination from a parent, relative, or friend with jobs or hobbies like these?		If "Yes" or "Don't Know" Perform a Blood Lead Test			
<input type="checkbox"/>	Radiator repair	<input type="checkbox"/>	House construction or repair	<input type="checkbox"/>	Chemical preparation
<input type="checkbox"/>	Pottery making	<input type="checkbox"/>	Battery manufacture or repair	<input type="checkbox"/>	Valve and pipe fittings
<input type="checkbox"/>	Lead smelting	<input type="checkbox"/>	Burning lead-painted wood	<input type="checkbox"/>	Brass/copper foundry
<input type="checkbox"/>	Welding	<input type="checkbox"/>	Automotive repair shop or junkyard	<input type="checkbox"/>	Refinishing furniture
<input type="checkbox"/>	Making fishing weights	<input type="checkbox"/>	Going to a firing range or reloading bullets	<input type="checkbox"/>	Other:
Sources of lead in food and remedies?					
<input type="checkbox"/>	Imported or glazed pottery such as a Mexican bean pot	<input type="checkbox"/>	Foods canned or packaged outside the U.S.		
<input type="checkbox"/>	Imported candy, (like Chaca Chaca) especially from Mexico	<input type="checkbox"/>	Remedies such as greta, azarcón, alarcón, alkohl, bali goli, coral, ghasard, liga, pay-loo-ah, rueda		
<input type="checkbox"/>	Nutritional pills other than vitamins				
<input type="checkbox"/>	Other:				

Cuestionario de Padre		Sí	No lo se	No	
1	¿Vive su hijo(a) o visita una casa, centro de guardería u otro edificio construida antes de 1978?				
2	¿Vive su hijo(a) o visita una casa, centro de guardería u otro edificio que está siendo pintada, remodelada, o en la que están pelando o lijando la pintura?				
3	¿Su hijo(a) come o mastica cosas que no son comida, como pedazos de pintura o tierra?				
4	¿Tienen parientes o compañeros de su hijo(a) que tienen o tuvieron altos niveles de plomo en la sangre?				
5	¿Es su hijo recién refugiado o adoptado del extranjero?				
6	¿Ha sido expuesto su hijo(a) a cualquier de los siguientes? (si SÍ, marque todos que apliquen):				
Contaminación de un padre, pariente, o amigo con trabajos o pasatiempos como estas?		Si "sí" o "no lo se" Le haga al niño una prueba de plomo en el sangre			
<input type="checkbox"/>	Reparación de radiadores	<input type="checkbox"/>	Construcción o reparación de casas	<input type="checkbox"/>	Preparación de químicos
<input type="checkbox"/>	Fabricación de cerámica	<input type="checkbox"/>	Fabricación o reparación de baterías	<input type="checkbox"/>	Partes sueltas para tubos de cañerías y válvulas
<input type="checkbox"/>	Industria del plomo	<input type="checkbox"/>	Quema de madera pintada con plomo	<input type="checkbox"/>	Fundición de latón/cobre
<input type="checkbox"/>	Soldadura	<input type="checkbox"/>	Taller mecánico para autos o lote de chatarra	<input type="checkbox"/>	Terminado de muebles
<input type="checkbox"/>	Fabricación de pesas para pescar	<input type="checkbox"/>	Ir a un campo de tiro o recargar balas	<input type="checkbox"/>	Otros:
Fuentes de plomo en comidas y remedios?					
<input type="checkbox"/>	Productos de cerámica importada o con recubrimiento de barniz, como una olla para frijoles de México				
<input type="checkbox"/>	Productos enlatados o empacados fuera de los Estados Unidos				
<input type="checkbox"/>	Dulces importados, (como Chaca Chaca) especialmente de México				
<input type="checkbox"/>	Remedios tradicionales como greta, azarcón, alarcón, alkohl, bali goli, coral, ghasard, liga, pay-loo-ah, rueda				
<input type="checkbox"/>	Píldoras alimenticias con excepción de las vitaminas				
<input type="checkbox"/>	Otros:				

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Pediatric Symptom Checklist (PSC)

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions, or learning, you may help your child get the best care possible by answering these questions.

Please indicate which statement best describes your child.

Please mark under the heading that best describes your child:

	Never	Sometimes	Often
1. Complains of aches and pains	1		
2. Spends more time alone	2		
3. Tires easily, has little energy	3		
4. Fidgety, unable to sit still	4		
5. Has trouble with teacher	5		
6. Less interested in school	6		
7. Acts as if driven by a motor	7		
8. Daydreams too much	8		
9. Distracted easily	9		
10. Is afraid of new situations	10		
11. Feels sad, unhappy	11		
12. Is irritable, angry	12		
13. Feels hopeless	13		
14. Has trouble concentrating	14		
15. Less interested in friends	15		
16. Fights with other children	16		
17. Absent from school	17		
18. School grades dropping	18		
19. Is down on him or herself	19		
20. Visits the doctor with doctor finding nothing wrong	20		
21. Has trouble sleeping	21		
22. Worries a lot	22		
23. Wants to be with you more than before	23		
24. Feels he or she is bad	24		
25. Takes unnecessary risks	25		
26. Gets hurt frequently	26		
27. Seems to be having less fun	27		
28. Acts younger than children his or her age	28		
29. Does not listen to rules	29		
30. Does not show feelings	30		
31. Does not understand other people's feelings	31		
32. Teases others	32		
33. Blames others for his or her troubles	33		
34. Takes things that do not belong to him or her	34		
35. Refuses to share	35		

Total score _____

Does your child have any emotional or behavioral problems for which she or he needs help? () N () Y

Are there any services that you would like your child to receive for these problems? () N () Y

If yes, what

services? _____



HEALTH QUESTIONNAIRE

Patient Name: _____ **Date:** _____

Please answer YES or NO to the following questions. If you answer YES to any question please explain in the space provided below.

- 1. **Yes**__ **No**__ Since the last check-up, have you had any injury or serious illness?
- 2. **Yes**__ **No**__ Since the last check-up, have you been hospitalized overnight?
- 3. **Yes**__ **No**__ Since the last check-up, have you had surgery?
- 4. **Yes**__ **No**__ Do you take any medication?
- 5. **Yes**__ **No**__ Have you experienced lightheadedness, dizziness, or chest pain during exercise?
- 6. **Yes**__ **No**__ Have you ever fainted during exercise?
- 7. **Yes**__ **No**__ Is there a family history of heart disease before 50 years old?
- 8. **Yes**__ **No**__ Do you have asthma?
- 9. **Yes**__ **No**__ Have you experienced cough, wheezing or shortness of breath during exercise?
- 10. **Yes**__ **No**__ Have you ever had a concussion or a significant head injury?
- 11. **Yes**__ **No**__ Do you have a history of severe headaches?
- 12. **Yes**__ **No**__ Have you ever experienced numbness or tingling in your extremities?
- 13. **Yes**__ **No**__ Do you have a single organ (kidney, testicle, etc.)?

If you have answered YES to any question, please explain below.

Signature of parent or legal guardian

Date