

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

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

CHILD'S BIRTHDATE _____

24 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, alkoohl, 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
~Do you live in military housing?	() yes () no () don't know
Hearing Screening	
~ Do you have any concerns about your child's hearing?	() yes () no () don't know
Vision Screening	
~Do you have any concerns about your child's vision?	() yes () no () don't know
Dental screening	
~Does your child take a bottle of juice or milk to bed?	() yes () no () don't know
~Does your child get his/her teeth brushed at least once per day?	() yes () no () don't know
~ Has your child seen a dentist?	() yes () no () don't know
Anemia screening	
~Does your child have a history of anemia?	() yes () no () don't know
~Has your child required iron supplements in the past?	() yes () no () don't know
~Does your child drink greater than 24 ozs milk/day?	() yes () no () don't know
TB Screening	
~Has your child traveled to foreign countries? Name of countries _____	() yes () no () don't know
~Is your child routinely exposed to anyone with chronic cough?	() yes () no () don't know
~Does anyone living at home have a +PPD (TB skin test) skin test?	() yes () no () don't know

Please also complete the ASQ screen and MCHAT assessment.

Your child's age in months rounded to the nearest half month is _____ months?
(as an example...if your child is 24 months and 3 days old, please write 24 in the blank above, but if your child is 24 months and 29 days, please write 25 in the above blank).