

LEAD EXPOSURE RISK QUESTIONNAIRE

Child's Name	DOB
Health Care Provider's Name	

Please answer questions 1 through 5. Use a check (✓) to mark the box next to your answer choice.

Questions

Age: ____ Date: ____

1	Is your child enrolled in Medicaid?	Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/>
2	Does your child receive WIC or Head start benefits?	Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/>
3	Does your child live in or regularly visit a house (or child care facility) that was built before 1978?	Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/>
4	Does your child live in or regularly visit a house (or child care facility) built before 1978 with recent or ongoing renovations or remodeling (within the last 6 months)?	Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/>
5	Does your child have a sibling or playmate that has or did have lead poisoning?	Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/>
	For office use only: Based on responses, is a blood lead test indicated?	Yes <input type="checkbox"/> No <input type="checkbox"/>

A "Yes" response to *any* of the questions indicates the child should be tested. A "don't know" response to questions 3 and 4 indicates the child should be tested.

HEALTHY HOMES & LEAD POISONING PREVENTION PROGRAM



1-800-897-LEAD