

## WELL VISIT QUESTIONNAIRE



Patient's Name \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Please complete the **front** of this page only. Thank you in advance for completing this form.

Does the patient take any daily or as-needed medication (include fluoride, over the counter medication, herbal medication, vitamins, topical creams, birth control, etc.)?  Yes  No Please list medications and doses \_\_\_\_\_

**LEAD EXPOSURE ASSESSMENT (complete only if patient is 6 years old or younger)**

- Is there any concern about lead exposure for the patient?  Unknown  Yes  No
- Has the patient moved from another country or major metropolitan area in the last 12 months?  Unknown  Yes  No
- Does the patient live within the city limits of Minneapolis or St. Paul?  Unknown  Yes  No
- During the past six months, has the patient lived in or regularly visited a home, childcare facility, school, or other building built before 1950?  Unknown  Yes  No
- During the past six months, has the patient lived in or regularly visited a home, childcare facility, school, or other building built before 1978 with recent or ongoing repair, remodeling, or damage (such as water damage or chipped paint)?  Unknown  Yes  No
- Has the patient or his/her sibling, playmate, or housemate ever had a high lead level?  Unknown  Yes  No
- Does the patient receive Medical Assistance, WIC, or MN Care?  Unknown  Yes  No

**TUBERCULOSIS "TB" EXPOSURE ASSESSMENT**

- Does the patient have contact with anyone with tuberculosis?  Yes  No
- Has a family member ever had a positive tuberculosis skin test (PPD, Mantoux, or Tine test)?  Yes  No
- Is the patient or parent(s) from a country with high levels of tuberculosis?  Yes  No
- Has the patient traveled to a country with high levels of tuberculosis, and had contact with the local people for more than one week?  Yes  No

**SMOKE EXPOSURE ASSESSMENT**

- Does the patient smoke or use chewing tobacco?  Yes  No
- Does either parent of the patient smoke?  Yes  No
- Does the patient have regular exposure to someone who smokes, either inside or outside, or in the car?  Yes  No
- Does the patient or other person who smokes desire information about quitting smoking?  Yes  No

**SAFETY ASSESSMENT**

- Are there any guns in any house where the patient lives or visits frequently?  Yes  No
- If so, are they locked up or have safety locks, and kept out of sight?  Yes  No
- Is there any concern for the safety of the patient or exposure to violence from anyone in the household?  Yes  No
- Is there any concern for excessive alcohol or drug use by anyone in the household?  Yes  No
- Is there any concern for mental health problems in any of the patient's caregivers or family?  Yes  No
- Does the patient always use a car seat, booster seat, or seat belt?  Yes  No
- If under 1 year of age or under 20 pounds, does the patient use a rear-facing car seat?  N/A  Yes  No
- If under age 12, does the patient always sit in the back seat?  N/A  Yes  No
- Does the patient always use a helmet when biking, roller blading, skate boarding, riding an ATV, skiing, etc.?  Yes  No

**FLUORIDE SOURCE**

- Does your child have a source of fluoride?  Yes  No
- If yes, what is the source? (city water, water at school, supplements, dental treatments, other) \_\_\_\_\_

Form completed by (print): \_\_\_\_\_ Relation to patient: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Prov. Rev.
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