Loudoun Pediatric Associates

Tuberculosis Risk Factor Questionnaire

Parent /guardian, please circle YES or NO.

Patient name:_____ DOB:_____ Today's Date:_____

Since your child's last visit, has your child:

[Yes] [No] - Had close contact with anyone who has active tuberculosis (TB) disease or is being evaluated for TB?

[Yes] [No] - Been born in, lived in, or traveled to a country where TB is common and had substantial contact with the local population (for example staying with relatives, attending school or daycare, or living in the community rather than tourism only) for one month or more?

[Yes] [No] - Had a household member or caregiver who was born in or frequently travels to a country where TB is common, or who has been diagnosed with TB infection or TB disease?

[Yes] [No] - Has your child developed a condition or started medication that weakens the immune system (such as cancer chemotherapy, organ transplant, biologic immune-modifying medications, or advanced HIV infection)?

Lead Risk Factor Questionnaire

IF YOUR CHILD IS 1, 2, OR 5 YEARS OF AGE PLEASE CIRCLE THE CORRECT ANSWER FOR YOUR CHILD.

[Yes] [No] - Receives benefits from Medicaid or WIC. (IF YES…MUST HAVE LEAD TEST)

**(Medicaid requires all children [who have Medicaid] to have a lead test at 12 months, & 24 months of age. Children between 24 and 72 months who have not had a lead test, need to have one test)

[Yes] [No] - Lives in or regularly visits a home, preschool or daycare built before 1950.

[Yes] [No] –Lives in or regularly visits an un-renovated: home, preschool or daycare built before 1978 with chipping or peeling paint or with planned renovations.

[Yes] [No] - Has a sibling, house mate or playmate being followed or treated for lead poisoning.

[Yes] [No] - Lives with an adult whose job or hobby involves exposure to lead.

[Yes] [No] - Lives near an active lead smelter, battery recycling or other heavy industrial building.

[Yes] [No] - Are there any concern/worries about possible lead ingestion or exposure?

HEALTHCARE PROVIDER ONLY: Needs PPD? YES NO	**HEALTHCARE PROVIDER ONLY: Needs LEAD? YES NO**
Provider signature:_____	Provider signature:_____