SOUTHDALE PEDIATRIC ASSOCIATES, LTD

Risk Assessment

Date: _____

Patient Name _____ **DOB** _____ **Age**_____ **Dr.** _____

✓ *"All Patients"* ENVIRONMENTAL SMOKE Exposure

1. Does the patient smoke or use chewing tobacco?	**YES**	**NO**
2. Is a parent of the patient a smoker?	**YES**	**NO**
3. Is the patient exposed to someone who smokes?	**YES**	**NO**
4. Is smoking cessation information desired?	**YES**	**NO**
If **yes** to any of the above questions, please explain:		

FLUORIDE / DENTAL Assessment

Source of Drinking Water?	**City Well Bottled Filtered Reverse Osmosis**
Fluoride Supplement?	**YES NO**
Dentist	**Last Dental Visit? Indicate Month/Yr:** _____/_____

SOCIAL Risk Assessment

1. Do you feel that you have inadequate housing?	**YES**	**NO**
2. Do you feel that obtaining food is a problem?	**YES**	**NO**
3. Do you feel unsafe in your living environment?	**YES**	**NO**
4. Do you have concerns of alcohol abuse in your household	**YES**	**NO**
5. Do have concerns of drug abuse in your household?	**YES**	**NO**
If **yes** to any of the above questions, please explain:		

TUBERCULOSIS Risk Assessment

1. Is patient in close contact with a person who has infectious tuberculosis?	**YES**	**NO**
2. Is patient in contact with a person incarcerated in past 5 years?	**YES**	**NO**
3. Is patient exposed to individuals at risk for TB? (HIV infected, homeless, nursing home residents, institutionalized persons, illicit drug users, or migrant farm workers)	**YES**	**NO**
4. Does patient live in a high risk TB community?	**YES**	**NO**
5. Does patient have HIV or at risk for HIV infection?	**YES**	**NO**
6. Is patient foreign born, a refugee or a migrant?	**YES**	**NO**
7. Does patient have a medical condition/treatment that suppresses the immune system?	**YES**	**NO**
8. Has patient travelled outside of the U.S. since last visit?	**YES**	**NO**
If **yes** to any of the above questions, please explain:		

✓ *Only Patients 12 months to 5 years"* ENVIRONMENTAL LEAD Risk Assessment

1. Does patient live in or regularly visit a daycare or house built before 1978?	**YES**	**NO**
2. Does patient live in or regularly visit a house built before 1978 that has chipping paint or been remodeled in the past 6 months?	**YES**	**NO**
3. Does patient live with someone who works with lead or has hobbies that use lead?	**YES**	**NO**
4. Has patient ever received a lead test?	**YES**	**NO**
5. Does patient have a sibling/playmate that has had lead poisoning?	**YES**	**NO**
6. Does patient sometimes eat non-food items such as soil or paint?	**YES**	**NO**
7. Does patient live near a highway?	**YES**	**NO**
8. Does patient use homemade remedies or pottery?	**YES**	**NO**
If **yes** to any of the above questions, please explain:		

✓ "*Only Patients 2 years and older"* CHOLESTEROL Risk Assessment

1. Does patient have risk factors for future heart disease? (diabetes, obesity, physical inactivity, etc.)	**YES**	**NO**
2. Is there a family history (parent/grandparent) of coronary/peripheral vascular disease under age 55?	**YES**	**NO**
3. Is there a family history of elevated blood cholesterol?	**YES**	**NO**
If **yes** to any of the above questions, please explain:		