

Maryland Healthy Kids Program Medical/Family History Questionnaire

Patient Name: _____		Date of Birth: _____	Sex: (circle) Male <input type="checkbox"/> Female <input type="checkbox"/>																																																																																												
Form Completed By: _____	Today's Date: _____	Relationship: _____																																																																																													
PREGNANCY AND BIRTH HISTORY		PSYCHOSOCIAL HISTORY																																																																																													
Name of Hospital: _____ Illnesses during pregnancy? No <input type="checkbox"/> Yes <input type="checkbox"/> Medications during pregnancy? No <input type="checkbox"/> Yes <input type="checkbox"/> Alcohol/Drug Abuse? No <input type="checkbox"/> Yes <input type="checkbox"/> Problems at birth? No <input type="checkbox"/> Yes <input type="checkbox"/> Describe: _____ Type of delivery? <input type="checkbox"/> Vaginal <input type="checkbox"/> C-section Birth Weight _____ Discharge Weight _____ Did baby receive Hepatitis B vaccine? No <input type="checkbox"/> Yes <input type="checkbox"/> Date of Hepatitis B immunization: _____ Newborn Hearing Screen? No <input type="checkbox"/> Yes <input type="checkbox"/>		Who lives in household? _____ How many? _____ <input type="checkbox"/> Rent? <input type="checkbox"/> Own? <input type="checkbox"/> Shelter? Who cares for child? _____ Date of Birth? Mother _____ Father _____ Are parents working? Mother No <input type="checkbox"/> Yes <input type="checkbox"/> Father No <input type="checkbox"/> Yes <input type="checkbox"/> Foster Care? _____ Dates: _____ Other Languages? _____																																																																																													
FAMILY HISTORY		MEDICAL HISTORY																																																																																													
Has anyone in the family (parents, grand-parents, aunts/uncles, sisters/brothers) had: _____		Has your child ever had: _____																																																																																													
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NUTRITION QUESTIONNAIRE FOR CHILDREN AGES 1 TO 10

1. How would you describe your child's appetite?
 - Fair
 - Good
 - Poor

2. How many days per week does your family eat meals together?

3. How would you describe mealtimes with your child?
 - Always pleasant
 - Usually pleasant
 - Sometimes pleasant
 - Never pleasant

4. How many meals does your child eat per day? How many snacks?

5. Which of these foods did your child eat or drink last week?
(Check all that apply)

Grains:

- Bagels
- Bread
- Cereal/grits
- Crackers
- Muffins
- Noodles/pasta/rice
- Rolls
- Tortillas
- Other grains:.....

Vegetables

- Broccoli
- Carrots
- Corn
- Green beans
- Green salad
- Greens (collard, spinach)
- Peas
- Potatoes
- Tomatoes
- Other vegetables.....

Fruits

- Apples/ juice
- Bananas
- Grapefruit/juice
- Grapes/juice
- Melon
- Oranges/juice
- Peaches
- Pears
- Other fruits/ juice:.....

Milk and Milk Products

- Fat-free (skim) milk
- Low-fat (1%) milk
- Reduced-fat (2%) milk
- Whole milk
- Flavored milk
- Cheese
- Ice cream
- Yogurt
- Other milk and milk products:

Meal and Meal Alternatives

- Beef/hamburger
- Chicken
- Cold cuts/ deli meals
- Dried beans (for example, black beans, kidney beans, pinto beans)
- Eggs
- Fish
- Peanut butter/nuts
- Pork
- Sausage/bacon
- Tofu
- Turkey
- Other meal and meat alternatives:.....

Fats and Sweets

- Cake/cupcakes
- Candy
- Chips
- French fries
- Cookies
- Doughnuts
- Fruit-flavored drinks
- Soft drinks
- Pies
- Other fats and sweets:

NUTRITION QUESTIONNAIRE FOR CHILDREN AGES 1 TO 10

6. If your child is 5 years or younger, does he or she eat any of these foods? (Check all that apply.)
- Hot dogs
 - Marshmallows
 - Nuts and seeds
 - Peanut butter
 - Popcorn
 - Pretzels and chips
 - Raisins
 - Raw celery or carrots
 - Hard or chewy candy
 - Whole grapes
7. How much juice does your child drink per day? How much sweetened beverage (for example, fruit punch or soft drinks) does your child drink per day?
8. Does your child take a bottle to bed at night or carry a bottle around during the day?
- Yes No
9. What is the source of the water your child drinks? Sources include public, well, commercially bottled, and home system-processed water?
10. Do you have a working stove, oven, and refrigerator where you live?
- Yes No
11. Were there any days last month when your family didn't have enough food to eat or enough money to buy food?
12. Did you participate in physical activity (for example, walking or riding a bike) in the past week?
- Yes No
- If yes, on how many days and for how many minutes or hours per day?.....
13. Does your child spend more than 2 hours per day watching television and DVDs or playing computer games:
- Yes No
- If yes, how many hours per day?.....
14. Does your family watch television during meals?
- Yes No
15. What concerns or questions do you have about feeding your child or how your child is growing? Do you have any concerns or questions about your child's weight?

MARYLAND HEALTHY KIDS PROGRAM

Preventive Screen Questionnaire

Lead Risk Assessment:
(every well child visit from 6 months up to 6 years)

1. Has your child ever lived or stayed in a house or apartment that is built before 1978 (includes day care center, preschool home, home of babysitter or relative)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
2. Has your child ever lived outside the United States or recently arrived from a foreign country?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
3. Is anyone in the home being treated or followed for lead poisoning?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
4. Are there any current renovations or peeling paint in a home that your child regularly visits?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
5. Does your child lick, eat, or chew things that are not food (paint chips, dirt, railings, poles, furniture, old toys, etc.)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
6. Is there any family member who is currently working in an occupation or hobby where lead exposure could occur (auto mechanic, ceramics, commercial painter, etc.)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
7. Does your family use products from other countries such as health remedies, traditional remedies, spices, cosmetics or other products canned or packaged outside of the United States? Or store or serve food in leaded crystal, pottery or pewter? <i>Examples: Glazed pottery, Greta, Azarcon (Rueda, Coral, Liga), Litargiro, Surma, Kohl (Al kohl), Pay-loo-ah, Ayurvedic medicine, Ghassard).</i>	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N

Tuberculosis Risk Assessment:

(The assessment must be completed at 1, 6 and 12 months, and then annually starting at 36 months.)

	Date	Date	Date	Date	Date	Date	Date	Date	Date
1. Has your child been exposed to anyone with a case of TB or a positive tuberculin skin test, or received a tuberculosis vaccination?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
2. Was your child, or a household member, born in a high-risk country (countries other than the United States, Canada, Australia, New Zealand, or Western and North European countries)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
3. Has your child travelled (had a contact with resident populations) to a high-risk country for more than 1 week?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
4. Does your child have daily contact with adults at high risk for TB (e.g., those who are HIV infected, homeless, incarcerated, and/or illicit drug users)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
5. Does your child have HIV infection?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N

(A "yes" response or "don't know" to any question indicates a positive risk)

Patient Name: _____ Birth Date: _____

MARYLAND HEALTHY KIDS PROGRAM

Preventive Screen Questionnaire

Anemia Screening
(Starting at 11 years of age and annually thereafter)

1. (FEMALES AND MALES) Does the child/adolescent's diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?

Date	Date	Date	Date	Date	Date	Date	Date	Date	Date
Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N

2. (FEMALES AND MALES) Have you ever been diagnosed with iron deficiency anemia?

Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
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3. (FEMALES ONLY) Do you have excessive menstrual bleeding or other blood loss?

Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
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4. (FEMALES ONLY) Does your period last more than 5 days?

Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
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Heart Disease/Cholesterol Risk Assessment:
(2 years through 20 years)

1. Is there a family history of parents/grandparents under 55 years of age with a heart attack, heart surgery, angina or sudden cardiac death?

Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
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2. Has the child's mother or father been diagnosed with high cholesterol (240 mg/dL or higher)?

Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
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3. Is the child/adolescent overweight (BMI > 85th %)?

Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
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4. And is there a personal history of:

Smoking?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
Lack of physical activity?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
High blood pressure?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
High cholesterol?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
Diabetes mellitus?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N

(Refer to the AAP Clinical Guidelines for Childhood Lipid Screening)

STI/HIV Risk Assessment:
(11 years through 20 years)

1. Are you sexually active?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
2. If sexually active, have you had more than one partner?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
3. If sexually active, have you had unprotected sex, with opposite/same sex?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
4. Have you ever been sexually molested or physically attacked?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
5. Have you ever been diagnosed with any sexually transmitted diseases?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
6. Any body tattoos or body piercing of ears, navel, etc., including any performed by friends?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
7. Have you had a blood transfusion or are you a Hemophiliac?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
8. Any history of IV drug use by you, your sex partner, or your birth mother during pregnancy?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N

A "yes" response or "don't know" to any question indicates a positive risk

Patient Name: _____

Birth Date: _____

MENTAL HEALTH QUESTIONNAIRE

Maryland Healthy Kids Program

Date _____

Child's Name: _____ Date of Birth: _____

Managed Care Organization: _____ Child's Medicaid #: _____

Ages 10 – 12 years

Check all answers that may apply. This form may be filled out by the parent/guardian or health care provider.

Does your child have trouble paying attention? Yes No

Does your child often seem:

Distrustful of others? Yes No

To express strange thoughts? Yes No

Blame others? Yes No

Does your child have problems at school with:

Behavior? Yes No

Grades? Yes No

Skipping classes? Yes No

Do you have concerns about your child's:

Eating? Yes No

Sleep? Yes No

Weight? Yes No

Does your child often complain of "not feeling well"? Yes No

Does your child have trouble making or keeping friends? Yes No

Does your child often seem:

Sad? Yes No

Angry? Yes No

Nervous or afraid? Yes No

Does your child show any of these behaviors?

Destroy property? Yes No

Set fire? Yes No

Lie? Yes No

Steal? Yes No

Listen to music with violent message? Yes No

Hurt animal or smaller children? Yes No

Use alcohol? Yes No

Use drugs? Yes No

Smoke cigarettes? Yes No

Sexually active? Yes No

Continued on back →

MARYLAND HEALTHY KIDS PROGRAM

Maryland Department of Health and Mental Hygiene HealthChoice and
Acute Care Administration, Division of Children's Services

MENTAL HEALTH QUESTIONNAIRE

Maryland Healthy Kids Program

Page Two

Is there a history of injuries, accidents? Yes No

If yes, please specify: _____

Is there any history of maltreatment or abuse? Yes No

If yes, please specify: _____

Is there a recent stress on the family or child such as:

Birth of a child Yes No

Moving Yes No

Divorce or separation Yes No

Death of a close relative Yes No

Fired or laid off Yes No

Legal problems Yes No

Others (Please specify): _____

Do you have other parenting concerns? Yes No

Please specify: _____

Provider: Give details of all **Positive** findings.

Provider's Signature

Date

Provider's Phone: (___ ___) / ___ ___ / ___ ___

THIS FORM MAY BE USED FOR MENTAL HEALTH REFERRALS

Child Receiving Referral: _____

Child's Address: _____

Child's Phone: _____

Referred to: **Maryland Public Mental Health System: 1-800-888-1965**

Reason for Referral: _____

MARYLAND HEALTHY KIDS PROGRAM

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