ANDREW RADER US ARMY CLINIC
PEDIATRIC CLINIC

6 Year Visit Bright Futures Medical Screening Questionnaire

Please answer the following questions about your child's health by circling Y, N, or Unsure

1. Does your child have a sibling or playmate who has or had lead poisoning?
   Yes No Unsure
2. Does your child live in or regularly visit a house or child care facility built before 1978 that is being or has recently been (within the last 6 months) renovated or remodeled?
   Yes No Unsure
3. Does your child live in or regularly visit a house or child care facility built before 1950?
   Yes No Unsure
4. Was your child born in a country at high risk for tuberculosis (countries other than the United States, Canada, Australia, New Zealand, or Western Europe)?
   Yes No Unsure
5. Has your child traveled (had contact with resident populations) for longer than 1 week to a country at high risk for tuberculosis?
   Yes No Unsure
6. Has a family member or contact had tuberculosis or a positive tuberculin skin test?
   Yes No Unsure
7. Is your child infected with HIV?
   Yes No Unsure
8. Does your child have parents or grandparents who have had a stroke or heart problem before age 55?
   Yes No Unsure
9. Does your child have a parent with elevated blood cholesterol (240 mg/dL or higher) or who is taking cholesterol medication?
   Yes No Unsure
10. Does your child eat a strict vegetarian diet?
    Yes No Unsure
11. If your child is a vegetarian, does your child take an iron supplement?
    Yes No Unsure
12. Does your child's diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?
    Yes No Unsure
13. Does your child have a dentist?
    Yes No Unsure
14. Does your child's primary water source contain fluoride?
    Yes No Unsure

DATE	PATIENT'S NAME	AGE	DOB	SPONSOR'S SS#