Patient Name: _____ **DOB:** _____ **Date:** _____

Lead Risk Assessment

Circle Yes or No.

1. Does your child live in or regularly visit a house/apt. that was built before 1978? ***Yes / No***

2. Does your child live in or often visit a house/apt. that is being remodeled or having paint removed? ***Yes / No***

3. Does your child live with or often visit with a child that had an elevated Blood Lead Level? ***Yes / No***

4. Does your child live with an adult whose job or hobby involves exposure to lead? ***Yes / No***

5. Does your child chew on or eat non-food items such as paint chips or dirt? ***Yes / No***

6. Does your child live near an active lead smelter, battery recycling plant, or other industry likely to release lead? ***Yes / No***

7. Does your child receive medicines such as Greta, Azarcon, Kohl or Pay-loo-ay? ***Yes / No***

Tuberculosis (TB) Risk Assessment

Circle Yes or No.

1. Does the child have any symptoms of TB (cough, fever, night sweats, loss of appetite, weight loss or fatigue) or an abnormal chest X-ray? ***Yes / No***

2. Has the child been in close contact to a person sick with active TB disease? ***Yes / No***

3. Was the child born outside the United States or has the child traveled outside the United States? ***Yes / No***

4. Does the child have a household member who was born outside the United States or who has traveled outside the United States? ***Yes / No***

5. Is the child exposed to a person who ***Yes / No***
   - Is currently in jail or who has been in jail in the past 5 years?
   - Has HIV?
   - Is homeless?
   - Lives in a group home?
   - Uses illegal drugs?
   - Is a migrant farm worker?

6. Does the child have HIV, at risk to have HIV or any other health problem that lowers the immune system? ***Yes / No***

7. Is the child/teen in jail or ever been in jail? ***Yes / No***

Hemoglobin Assessment

1. Does the child have history of prematurity or low birth weight? ***Yes / No***

2. Does the child have any feeding problems and/or sudden weight gain or loss? ***Yes / No***

3. Does the child have any chronic disease or major blood loss? ***Yes / No***

Edinburgh Postnatal Depression Scale[1] (EPDS)

Mothers Name:_____ Baby's Name: _____

Mothers Date of Birth: _____ Baby's Date of Birth: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:
- □ Yes, all the time
- ☒ Yes, most of the time
- □ No, not very often
- □ No, not at all

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - □ As much as I always could
   - □ Not quite so much now
   - □ Definitely not so much now
   - □ Not at all

2. I have looked forward with enjoyment to things
   - □ As much as I ever did
   - □ Rather less than I used to
   - □ Definitely less than I used to
   - □ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - □ Yes, most of the time
   - □ Yes, some of the time
   - □ Not very often
   - □ No, never

4. I have been anxious or worried for no good reason
   - No, not at all
   - Hardly ever
   - □ Yes, sometimes
   - □ Yes, very often
   - □

*5 I have felt scared or panicky for no very good reason
   - □ Yes, quite a lot
   - □ Yes, sometimes
   - □ No, not much
   - □ No, not at all

*6. Things have been getting on top of me
   - □ Yes, most of the time I haven't been able to cope at all
   - □ Yes, sometimes I haven't been coping as well as usual
   - □ No, most of the time I have coped quite well
   - □ No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - □ Yes, most of the time
   - □ Yes, sometimes
   - □ Not very often
   - □ No, not at all

*8 I have felt sad or miserable
   - □ Yes, most of the time
   - □ Yes, quite often
   - □ Not very often
   - No, not at all

*9 I have been so unhappy that I have been crying
   - Yes, most of the time
   - Yes, quite often
   - □ Only occasionally
   - □ No, never

*10 The thought of harming myself has occurred to me
   - □ Yes, quite often
   - □ Sometimes
   - □ Hardly ever
   - □ Never

Administered/Reviewed by_____Date _____

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199