Sunshine Pediatrics of Florida - Screening Questionnaire

Patient Name
Date of Birth

Tuberculosis Screening Questionnaire	**Date**	**Date**	**Date**	**Date**	**Date**	**Date**
Chronic Cough(Greater than 3 weeks)	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Production of Sputum	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Blood Streaked Sputum	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Unexplained Weight Loss	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Fever	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Fatigue/Tiredness	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Night Sweats	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Shortness of Breath	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Signature						
Lead Screening Questionnaire	**Date**	**Date**	**Date**	**Date**	**Date**	**Date**
Does yourChild live in/visit house or building built before 1978?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Is Child exposed to vinyl mini blinds, lead pipes, lead solder joints	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Does your child have mother, sibling, or playmate who has or did have lead poisoning?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Does your child come in contact with and adult whose job/hobby involves lead exposure?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Have you seen your child eat dirt or paint chips?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Does your child eat food from metal cans, leaded crystal, ceramic, folk remedies?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Does your child play in loose soil near busy road or industrial site(battery plant/lead smelter)?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Has your child lived in foster care home or country other then the United states?	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Signature						
Urinalysis Screening(FOR OFFICE USE ONLY)	**Date**	**Date**	**Date**	**Date**	**Date**	**Date**
Glucose						
Ketones						
Specific Gravity						
Blood						
pH						
Protein						
Nitrites						
Leukocyte Esterase						