Ohio Department of Health

APPENDIX B

Childhood Lead Exposure Questionnaire

Each section of this questionnaire should be completed as part of a public health response to children with an elevated blood level or lead poisoning as defined in Ohio Revised Code section 3701-30-01.

For further information on this form call **1-877-LEAD-SAFE (1-877-532-3723).**

Date _____

I. DEMOGRAPHICS

Name _____ DOB _____ ☐ Male ☐ Female

Birth Country _____ Ethnicity _____ Race _____ Medicaid # _____

Lived outside US in last year? ☐ **Yes** ☐ **No** Country _____ Date moved to U.S. _____

Other children less than 6 years old in household

Name	Relationship	DOB

Current address _____

Date child moved in? _____ Year built? _____ ☐ Own ☐ Rent

If rented, are there any rent subsidies? ☐ Public housing authority ☐ Section 8 ☐ Other _____

Other Addresses	Date child present	Date child no longer present

Guardian Name	Relationship	Occupation	Interviewed?
			☐ Yes ☐ No
			☐ Yes ☐ No

Home Phone_____ Mobile Phone _____ May we text you? ☐ Yes ☐ No

Email _____

II. POTENTIAL EXPOSURE

A. Work/Hobby

WORK

Does anyone who spends time with your child work with lead (e.g. foundry, scrapping, construction, automotive, shooting range, or manufacturing)? ☐ **Yes** ☐ **No**

Who _____ Occupation:_____

Source of exposure? _____

How long has this individual done this type of work? _____

Is clothing changed before leaving work? ☐ Yes ☐ No

Is shower taken before leaving work? ☐ Yes ☐ No

Are routine blood lead tests performed? ☐ Yes ☐ No

HOBBY

Does anyone who spends time with your child have a hobby that involves lead (e.g. hunting, fishing, scrapping, home remodeling, shooting range, or arts & crafts)? ☐ **Yes** ☐ **No**

Who? _____

How often are these activities done? _____ Are the hobbies done inside the building? ☐ Yes ☐ No

What does the hobby involve?_____

If hobby is done outside the home, is the clothing changed before entering the building? ☐ Yes ☐ No

Is shower taken before entering the home? ☐ Yes ☐ No

B. Home Remedies/Food/Drink

Does your child use herbal/ayurvedic remedies or vitamins (e.g. turmeric, azarcon, and greta)? ☐ **Yes** ☐ **No**

What remedy?_____

Date last given? _____ How many times in the last year? _____

How much? _____ How often? _____

For what purpose was the remedy given? _____

Do you have any imported or handmade ceramics in the building? ☐ **Yes** ☐ **No**

Describe their use _____

Are any of the following cosmetics ever used on your child: Kohl, Kajal, Surma or Sindoor? ☐ **Yes** ☐ **No**

How long (days) was it used?_____ Date last use _____

How many times was it used in the last year? _____

Does your child eat/drink food made in other countries? ☐ **Yes** ☐ **No** Food/drink item _____

Was the food item bought in the US? ☐ Yes ☐ No Where? _____

How much was given to your child? _____ Date last given? _____

How often given? _____ For how long? _____

II. POTENTIAL EXPOSURE

C. Behavior

Has your child been seen eating or mouthing other items (e.g. toys, newspapers, or magazines)? ☐ **Yes** ☐ **No**

Specify _____

Does your child suck his/her thumb and/or fingers? ☐ **Yes** ☐ **No**

D. Frequented Properties

Is your child cared for away from home ≥6 hours a week? ☐ **Yes** ☐ **No**

Name of caregiver _____ Phone _____

Address _____

How many hours/week? _____ Start date _____ End date _____

Building condition _____ Construction date_____

Name of caregiver _____ Phone _____

Address _____

How many hours/week? _____ Start date _____ End date _____

Building condition_____ Construction date _____

Does your child attend child care, pre-school, or grade school? ☐ **Yes** ☐ **No**

Name of child care _____ Phone _____

Address _____

How many hours/week? _____ Start date _____ End date _____

Building condition _____ Construction date_____

Name of school _____ Phone _____

Address _____

How many hours/week?_____ Start date _____ End date _____

Building condition _____ Construction date _____

III. ENVIRONMENTAL QUESTIONS

	Current Residence		Previous Address		Child Care Facility		School		Address: _____	
PAINT QUESTIONS										
Any recent repainting/remodeling?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Comment: _____										
Any paint chips in window troughs or on window sills?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Comment: _____										
Chipping or flaking paint inside or outside?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Comment: _____										
Chipping or flaking paint on an outbuilding or other structure?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Comment: _____										
Has your child chewed on painted surfaces, eaten paint chips, or picked at deteriorated paint?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Comment: _____										
SOIL QUESTIONS										
Is there any bare dirt outside?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Comment: _____										
Has your child eaten any dirt or gotten it in his/her mouth?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Comment: _____										
Are there any paint chips on the ground outside?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Comment: _____										
WATER QUESTIONS										
Does the property obtain water from a well?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Comment: _____										
Does your child drink tap water or eat foods cooked in it?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Comment: _____										
Do you use the water immediately?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Comment: _____										
ON-SITE NEEDED? (LEAD INVESTIGATOR ONLY FOR EBLL ≥10 µG/DL)										
On-site investigation necessary?	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Comment: _____										

Public Health Lead Investigator (print) **(Signature)** **Date**

PROPERTY OF CONCERN: _____

Property Owner Name _____ Phone Number _____

IV. EXPOSURE

A. Residential

Please list below any deteriorated paint from the home visit including all areas of the home (e.g. interior/exterior of home, porches, decks, out buildings, and garages) as well as proximity to off-site lead sources (e.g. industry, major roadways, and construction sites).

_____

_____

_____

_____

_____

_____

_____

_____

B. Other Sources

List other potential sources discussed (e.g. antique furniture, toys, and pets).
Description (including brand name if applicable):

_____

_____

_____

_____

_____

Duration of use/exposure: _____

Have these potential sources been tested? ☐ Yes ☐ No

By whom? _____

Needs to be completed by a Local Lead Poisoning Case Manager.

V. MEDICAL/DEVELOPMENTAL INFORMATION

A. Nutrition Information

Does your family receive food stamps (SNAP)? ☐ **Yes** ☐ **No**

Was a nutrition assessment done on your child or is your child enrolled in the WIC program? ☐ **Yes** ☐ **No**

By whom?_____

Is or was your child breastfed? ☐ **Yes** ☐ **No** During what ages? _____

Has your child ever been anemic (low iron)? ☐ **Yes** ☐ **No** When? _____

Has your child been given iron supplements? ☐ **Yes** ☐ **No**

Are you concerned about your child's nutrition or is your child a picky eater? ☐ **Yes** ☐ **No**

Do you feel that your family needs help getting food? ☐ **Yes** ☐ **No**

B. Developmental Information

Has child had developmental testing or is your child enrolled in the *Help Me Grow Program?* ☐ **Yes** ☐ **No**

What type of testing?_____

Have any developmental delays been identified in your child? ☐ **Yes** ☐ **No**

Does your child receive any special services currently (speech, physical or occupational therapy)? ☐ **Yes** ☐ **No**

What kind of therapy? _____

Is your child's development progressing as you have expected? ☐ **Yes** ☐ **No**

If no, explain_____

Notes for document other delays:

_____

_____

_____

_____

_____

_____

_____

V. MEDICAL/DEVELOPMENTAL INFORMATION

C. Medical Information

Who is your child's primary care physician (PCP)? _____ Has the PCP been notified? ☐ Yes ☐ No

Does your family have health insurance? ☐ **Yes** ☐ **No** Specify _____

Is your child currently on medication? ☐ **Yes** ☐ **No** Specify _____

Does your child have any other medical problems (e.g. asthma or diabetes)? ☐ **Yes** ☐ **No**

Specify _____

Has your child had any symptoms of lead poisoning (headache, stomachache, irritability, etc.)? ☐ **Yes** ☐ **No**

Specify _____

D. Chelation

Has your child received chelation therapy? ☐ **Yes** ☐ **No** What chelating agent _____

Start date _____ End date _____

Was your child hospitalized for chelation? ☐ **Yes** ☐ **No**

Institution? _____ Physician? _____

E. Referrals

Do you consent to have your child screened for developmental delays at no cost to you? ☐ **Yes** ☐ **No**

Do you consent to having your case referred to other programs? (Check each below for all "Yes" answers)

☐ Healthy Start/Families (Medicaid) ☐ Help Me Grow ☐ School system ☐ Remediation Services

☐ HEPA Vacuum Loan Program ☐ WIC ☐ Primary Care Provider ☐ Head Start

☐ BCMH ☐ Iron Testing

_____

Name and Title of Person Completing Questionnaire (print) (Signature) Date