Maryland Healthy Kids Program

Date____

Child's Name:	Date of Birth Child's Medicaid #	1: #:	
	Ages 3 – 5 years		
Check all answers that may apply. care provider.	Check all answers that may apply. This form may be filled out by the parent/guardian or health care provider.		
Does your child often wet or so	oil his pants?	☐ Yes	□No
Does your child have problems	s at day care or school?	☐ Yes	□No
Paying attention?			☐ No ☐ No ☐ No
	ers?		☐ No ☐ No
Does your child get tired easily	?	☐ Yes	□No
Angry? Nervous or afraid? Cranky?		☐ Yes ☐ Yes ☐ Yes ☐ Yes ☐ Yes	No No No No No No
Does your child have trouble s	sleeping?	☐ Yes	☐ No
Does your child have problems	s with eating?	☐ Yes	☐ No
Is your child often mean to ani	imals or smaller children?	☐ Yes	□No
•	ccidents?	☐ Yes	□ No

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MARYLAND HEALTHY KIDS PROGRAM

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

Maryland Healthy Kids Program

Date____

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Is there any history of maltreatment or abuse?
Is there a recent stress on the family or child such as: Birth of a child?
Do you have other parenting concerns?
Provider: Give details of all Positive findings.
Provider's Signature Provider's Phone: () //
THIS FORM MAY BE USED FOR MENTAL HEALTH REFERRALS Child Receiving Referral: Child's Address: Child's Phone: Referred to: MD Public Mental Health System: 1-800-888-1965 Reason for Referral:

MARYLAND HEALTHY KIDS PROGRAM

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

Preventive Screen				5.4	Data	Dete	Date
Lead Risk Assessment: (every well child visit from 6 months up to 6 years)	Date	Date	Date	Date	Date	Date	
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	<u></u> Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
2. 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
3. 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
4. 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
5. 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
Tuberculosis Risk Assessment: (Starting at 1 month of age and annually thereafter)	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?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
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
 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
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
5. Does your child have HIV infection?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Anemia Screening	Date	Date	Date	Date	Date	Date	Date
(Starting at 11 years of age and annually thereafter)							
1. Does your diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
2. Have you ever been diagnosed with iron deficiency anemia?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
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
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

Patient Name:	Birth Date:

Preventive Screen Questionnaire Date **Date Date** Date Date Date Date Heart Disease/Cholesterol Risk Assessment: (2 years through 20 years) Y/N Y/N Y/N 1. Is there a family history of parents/grandparents under 55 years of age with a heart attack, Y/N Y/NY/NY/N heart surgery, angina or sudden cardiac death? Y/N Y/N Y/N 2. Has the child's mother or father been diagnosed with high cholesterol (240 mg/dL or higher)? Y/N Y/NY/N Y/NY/N 3. Is the child/adolescent overweight (BMI > 85th %)? Y/N Y/N Y/N Y/NY/NY/N 4. And is there a personal history of: Y/N Y/N Y/N Y/N Y/N Y/N Y/NSmoking? Y/N Y/N Y/N Y/N Y/N Y/N Y/NLack of physical activity? Y/N Y/N Y/NY/NY/N Y/N Y/NHigh blood pressure? Y/N Y/N Y/N Y/N Y/NY/N Y/NHigh cholesterol? Y/N Y/N Y/N Y/N Y/N Y/N Y/N Diabetes mellitus? (Refer to the AAP Clinical Guidelines for Childhood Lipid Screening) Date Date Date STI/HIV Risk Assessment: Date Date Date Date (11 years through 20 years) Y/N Y/N Y/N Y/N Y/NY/N Y/N Have you had a blood transfusion or are you a Hemophiliac? Y/N Y/N Y/N Y/N Y/NY/NY/NHave you ever been sexually molested or physically attacked? 2. Y/N Y/N Y/NY/N Y/NY/NY/N Have you ever been diagnosed with any sexually transmitted diseases? Y/N Y/N Y/N Y/N Y/N Y/N Y/NAny 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 If sexually active, have you had unprotected sex, with opposite/same sex? Y/N Y/N Y/N Y/N Y/N Y/NY/N If sexually active, have you had more than one partner? 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)

Any body tattoos or body piercing of ears, navel, etc., including any performed by friends?

Patient Name:	Birth Date:
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NUTRITION QUESTINONNAIRE FOR CHILDREN AGES 1 TO 10 1. How would you describe your child's **Fruits** appetite? ☐ Apples/juice ☐ Fair □ Bananas ☐ Good □ Grapefruit/juice ☐ Poor ☐ Grapes/juice ☐ Melon 2. How many days per week does your □ Oranges/juice family eat meals together? □ Peaches ☐ Pears ☐ Other fruits/ juice:..... Milk and Milk Products 3. How would you describe mealtimes ☐ Fat-free (skim) milk with your child? ☐ Low-fat (1%) milk □ Always pleasant ☐ Reduced-fat (2%) milk □ Usually pleasant ☐ Whole milk □ Sometimes pleasant ☐ Flavored milk □ Never pleasant ☐ Cheese ☐ Ice cream 4. How many meals does your child eat ☐ Yogurt per day? How many snacks? ☐ Other milk and milk products: **Meal and Meal Alternatives** □ Beef/hamburger 5. Which of these foods did your child ☐ Chicken eat or drink last week? ☐ Cold cuts/ deli meals (Check all that apply) ☐ Dried beans (for example, black beans, Grains: kidney beans, pinto beans) □ Bagels □ Eggs □ Bread ☐ Fish ☐ Cereal/grits □ Peanut butter/nuts □ Crackers □ Pork ☐ Muffins □ Sausage/bacon □ Noodles/pasta/rice □ Tofu ☐ Rolls □ Turkey ☐ Tortillas ☐ Other meal and ☐ Other grains:..... meat alternatives:..... **Vegetables Fats and Sweets** ☐ Broccoli □ Cake/cupcakes ☐ Carrots ☐ Candy ☐ Corn ☐ Chips ☐ Green beans □ French fries □ Green salad □ Cookies ☐ Greens (collard, spinach) □ Doughnuts

09/30/2014

□ Fruit-flavored drinks

☐ Other fats and sweets:

□ Soft drinks

☐ Pies

☐ Peas

☐ Potatoes

□ Tomatoes

☐ Other vegetables.....

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

09/30/2014 2 November 2

Maryland Healthy Kids Program

Dat	:e

Child's Name:	Date of Birth:
Managed Care Organization:	Child's Medicaid #:
Ages 6 -	- 9 years
Check all answers that may apply. This form magare provider.	ay be filled out by the parent/guardian or health
Does your child often seem: Distrustful of others? Have trouble paying attention? Blame others?	🔲 Yes 🔲 No
Do you have concerns about your child's: Eating?	Yes No
Does your child have problems getting along Parent(s)? Other family members? Friends? School mates?	g with:
Does your child have problems at school wit	h:
Does your child often seem:	
Does your child often: Destroy property? Lie? Steal? Hurt animals or smaller children?	
	Continued on back →

MARYLAND HEALTHY KIDS PROGRAM

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

Maryland Healthy Kids Program

Date

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Is there a history of injuries, accidents?	o –			
Is there any history of maltreatment or abuse?	lo 			
Moving?	lo lo lo lo lo			
Do you have other parenting concerns?	lo 			
Provider: Give details of all <u>Positive</u> 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

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

Preventive Screen Questionnaire Date Date Date Date Date Date Date Lead Risk Assessment: (every well child visit from 6 months up to 6 years) Y/N Y/N Y/N Y/N1. Has your child ever lived or stayed in a house or apartment that is built before 1978 Y/N Y/NY/N (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 2. 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/N3. Are there any current renovations or peeling paint in a home that your child regularly visits? Y/N Y/N Y/NY/N Y/N Y/NDoes your child lick, eat, or chew things that are not food (paint chips, dirt, railings, poles, Y/Nfurniture, old toys, etc.)? Y/N Y/N Y/N Y/N Y/N Y/NIs there any family member who is currently working in an occupation or hobby where lead Y/N exposure could occur (auto mechanic, ceramics, commercial painter, etc.)? Date Date Date Date Date Date **Tuberculosis Risk Assessment:** Date (Starting at 1 month of age and annually thereafter) Y/N Y/N Y/N Y/N Y/N Y/N 1. Has your child been exposed to anyone with a case of TB or a positive tuberculin skin test? Y/N Y/N 2. Was your child, or a household member, born in a high-risk country (countries other than Y/N Y/N Y/N Y/N Y/N Y/N the United States, Canada, Australia, New Zealand, or Western and North European countries)? Y/N Y/N Y/N Y/NY/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/NY/N Y/N Y/N4. 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 5. Does your child have HIV infection? Y/N Y/N Y/N**Date** Date Date Date Date Date Date **Anemia Screening** (Starting at 11 years of age and annually thereafter) Y/NY/N Y/N Y/NY/N Y/NY/N Does your diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans? Y/N Y/N Have you ever been diagnosed with iron deficiency anemia? Y/N Y/N Y/N Y/N Y/N Y/N Y/N (FEMALES ONLY) Do you have excessive menstrual bleeding or other blood loss? Y/N Y/N Y/NY/N Y/NY/N Y/N Y/N Y/N Y/N Y/N Y/N (FEMALES ONLY) Does your period last more than 5 days?

Patient Name:	Birth Date:

Preventive Screen Questionnaire Date Date Date Date Date Date Date Heart Disease/Cholesterol Risk Assessment: (2 years through 20 years) Y/N 1. Is there a family history of parents/grandparents under 55 years of age with a heart attack, Y/N Y/N Y/N Y/N Y/N Y/N heart surgery, angina or sudden cardiac death? Y/N Y/N 2. Has the child's mother or father been diagnosed with high cholesterol (240 mg/dL or higher)? Y/N Y/NY/N Y/N Y/N3. Is the child/adolescent overweight (BMI > 85th %)? Y/N Y/N Y/NY/N Y/N Y/N Y/N4. And is there a personal history of: Y/N Y/N Y/N Y/N Y/N Y/N Y/N Smoking? Y/N Y/N Y/N Y/N Y/N Y/N Y/N Lack of physical activity? Y/N Y/N Y/NY/NY/N Y/N Y/N High blood pressure? Y/N Y/N Y/N Y/N Y/N Y/NY/N High cholesterol? Y/N Y/N Y/N Y/N Y/N Y/N Y/N Diabetes mellitus? (Refer to the AAP Clinical Guidelines for Childhood Lipid Screening) Date **Date** STI/HIV Risk Assessment: Date Date Date **Date** Date (11 years through 20 years) Y/N Y/N Y/N Y/N Y/N Y/N Y/N Have you had a blood transfusion or are you a Hemophiliac? Y/N Y/N Y/N Y/N Y/N Y/NY/NHave you ever been sexually molested or physically attacked? 2. Y/N Y/N Y/N Y/N Y/N Y/N Y/N Have you ever been diagnosed with any sexually transmitted diseases? Y/N Y/N Y/N Y/N Y/N Y/N Y/N 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/NY/N 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/NIf sexually active, have you had more than one partner? Y/N Y/N Y/N Y/N Y/N Y/NY/N

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

Any body tattoos or body piercing of ears, navel, etc., including any performed by friends?

D 424 N	Birth Date:
Patient Name:	Birtii Bate:

NUTRITION QUESTINONNAIRE FOR CHILDREN AGES 1 TO 10

1.	How would you describe your child's	Fru	ıits
	appetite?		Apples/ juice
	☐ Fair		Bananas
	☐ Good		Grapefruit/juice
	☐ Poor		Grapes/juice
			Melon
2.	How many days per week does your		Oranges/juice
	family eat meals together?		Peaches
			Pears
			Other fruits/ juice:
			k and Milk Products
3.	How would you describe mealtimes		Fat-free (skim) milk
•	with your child?		Low-fat (1%) milk
	☐ Álways pleasant		Reduced-fat (2%) milk
	☐ Usually pleasant		Whole milk
	☐ Sometimes pleasant		Flavored milk
	☐ Never pleasant		Cheese
	·		Ice cream
4.	How many meals does your child eat		
	per day? How many snacks?		Yogurt Other milk and
		Ц	
		B. 4 -	milk products:eal and Meal Alternatives
		_	
5	Which of these foods did your child		Beef/hamburger
٥.	eat or drink last week?		Chicken
	(Check all that apply)		Cold cuts/ deli meals
	Grains:		Dried beans (for example, black beans,
	☐ Bagels	_	kidney beans, pinto beans)
	□ Bread		Eggs
	☐ Cereal/grits		Fish
	☐ Crackers		Peanut butter/nuts
	☐ Muffins		Pork
	□ Noodles/pasta/rice		Sausage/bacon
	□ Rolls		Tofu
	☐ Tortillas		Turkey
	☐ Other grains:		Other meal and
	Vegetables		meat alternatives:
	☐ Broccoli	Fa	ts and Sweets
	☐ Carrots		Cake/cupcakes
			Candy
	☐ Corn		Chips
	☐ Green beans		French fries
	Green salad		Cookies
	☐ Greens (collard, spinach)		Doughnuts
	☐ Peas		Fruit-flavored drinks
	□ Potatoes		Soft drinks
	☐ Tomatoes		Pies
	☐ Other vegetables		Other fats and sweets:

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NUTRITION QUESTINONNAIRE 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.)	10.	Do you have a working stove, oven, and refrigerator where you live? ☐ Yes ☐ No
	 ☐ Hot dogs ☐ Marshmallows ☐ Nuts and seeds ☐ Peanut butter ☐ Popcorn ☐ Pretzels and chips ☐ Raisins ☐ Raw celery or carrots 	11.	Were there any days last month when your family didn't have enough food to eat or enough money to buy food?
	☐ Hard or chewy candy☐ Whole grapes	12.	Did you participate in physical activity (for example, walking or riding a bike) in the past week?
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?		☐ Yes ☐ No If yes, on how many days and for how many minutes or hours per day?
	uay:	13.	Does your child spend more than 2 hours per day watching television and DVDs or playing computer games: No If yes, how many hours per
8.	Does your child take a bottle to bed at night or carry a bottle around during the day? ☐ Yes ☐ No	14.	day? Does your family watch television during meals? ☐ Yes ☐ No
9.	What is the source of the water your child drinks? Sources include public, well, commercially bottled, and home system-processed water?	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?

09/30/2014

Maryland Healthy Kids Program

Date_____

Date of Birth: Child's Medicaid #:							
3 – 20 years							
Check all answers that may apply. This form may be filled out by the patient, parent/guardian or health care provider.							
iends? Yes No							
ne following:							

MARYLAND HEALTHY KIDS PROGRAM

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

Maryland Healthy Kids Program

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Is there a history of injuries, accidents? If yes, please specify:	Yes No
Is there any history of maltreatment or abuse?	Yes No
Is there a recent stress on the family or child such as: Birth of a child? Moving? Divorce or separation? Death of a close relative? Fired or laid off? Legal problems? Others (Please specify):	YesNo YesNo YesNo YesNo YesNo
Do you have other parenting concerns?Please specify:	. ☐ Yes ☐ No
Provider: Give details of all <u>Positive</u> findings.	
Provider's Signature Date	
Provider's Phone: () //	
THIS FORM MAY BE USED FOR MENTAL HEALTH REFE	ļ
Child's Address:	İ
Child's Phone:	
Referred to: Maryland Public Mental Health System: 1-800-888-1965	
Reason for Referral:	

MARYLAND HEALTHY KIDS PROGRAM

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

	Preventive Screen C	Questionna Date	aire Date	Date	Date	Date	Date	Date
Lea (eve	d Risk Assessment: ry well child visit from 6 months up to 6 years)							
•	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
2.	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
	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
	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
5.	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
	perculosis Risk Assessment: urting at 1 month of age and annually thereafter)	Date	Date	Date	Date	Date	Date	Date
•	Has your child been exposed to anyone with a case of TB or a positive tuberculin skin test?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
	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	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
3.	countries)? 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
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
5.	Does your child have HIV infection?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
An	emia Screening	Date	Date	Date	Date	Date	Date	Date
	arting at 11 years of age and annually thereafter)			-				
1.	Does your diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
2.	Have you ever been diagnosed with iron deficiency anemia?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
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
4.		Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N

Patient Name:	Birth Date:

Preventive Screen Qu Heart Disease/Cholesterol Risk Assessment: (2 years through 20 years)	Date	Date	Date	Date	Date	Date	Date
 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
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
3. Is the child/adolescent overweight (BMI > 85th %)?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
4. And is there a personal history of: Smoking? Lack of physical activity? High blood pressure? High cholesterol? Diabetes mellitus? (Refer to the AAP Clinical Guidelines for Childhood Lipid Screening)	Y/N Y/N Y/N Y/N Y/N	Y/N Y/N Y/N Y/N Y/N	Y/N Y/N Y/N Y/N Y/N	Y/N Y/N Y/N Y/N Y/N	Y/N Y/N Y/N Y/N Y/N	Y/N Y/N Y/N Y/N Y/N	Y/N Y/N Y/N Y/N
STI/HIV Risk Assessment: (11 years through 20 years)	Date	Date	Date	Date	Date	Date	Date
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 Y/N
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
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
4. 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	Y/N
5. 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
6. If sexually active, have you had more than one partner?7. 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

Patient Name:	Birth Date:
· · · · · · · · · · · · · · · · · · ·	

	Which of these meals or snacks did you	☐ Fitness water
	eat yesterday? (Check all that apply)	☐ Fitness water
	☐ Breakfast	☐ Juice
	☐ Lunch	☐ Regular soft drinks
		☐ Diet soft drinks
	☐ Dinner or supper	☐ Fruit-flavored drinks
	☐ Morning snack	☐ Sport drinks
	☐ Afternoon Snack	☐ Energy drinks
	☐ Evening/late-snack	☐ Recovery drinks
_	Decreased in the second section of the section of t	☐ Fat-free (skim) milk
2.	Do you skip breakfast 3 or more times a	□ Low-fat (1%) milk
	week?	☐ Reduced-fat (2%) milk
	☐ Yes ☐ No	☐ Whole milk
	Do you skip lunch 3 or more times a	 Flavored milk (for example, chocolate,
	week?	strawberry)
	☐ Yes ☐ No	□ Coffee or tea
	Do you skip dinner or supper 3 or more	☐ Beer, wine, or hard liquor
	times a week?	
	☐ Yes ☐ No	10. Which of these foods did you eat last week?
_	- 20	(Check all that apply)
3.	Do you eat dinner or supper with your	Grains:
	family 4 or more times a week?	□ Bagels
	☐ Yes ☐ No	☐ Bread
		☐ Cereal/grits
4.	Do you fix or buy the food for any of	☐ Crackers
	your family's meals?	☐ Muffins
	☐ Yes ☐ No	☐ Noodles/pasta/rice
_	Do you eat or take out a meal from a	☐ Rolls
٥.	fast food restaurant 2 or more times a	☐ Tortillas
	week?	☐ Other grains:
	□ Yes □ No	Vegetables
	□ fes □ NO	☐ Broccoli
c	Are you on special diet for medical	☐ Carrots
υ.	·	☐ Com
	reasons?	☐ Green beans
	□ Yes □ No	☐ Green salad
_	A	☐ Greens (collard, spinach)
1.	Are you a vegetarian?	☐ Peas
	☐ Yes ☐ No	☐ Potatoes
_		☐ Tomatoes
8.	Do you have any problems with your	☐ Other vegetables
	appetite, like not feeling hungry, or	Fruits
	feeling hungry all the time?	☐ Apples/ juice
	□ Yes □ No	☐ Bananas
_		☐ Grapefruit/iuice
9	. Which of the following did you drink last	☐ Grapes/juice
	week?(Check all that apply)	•

	Melon	12.	Were there any days last month when your
	Oranges/juice		family didn't have enough food to eat or
	Peaches		enough money to buy food?
	Pears		☐ Yes ☐ No
	Other fruits/juice:		
Mill	k and Milk Products	13.	Are you concerned about your weight?
	Fat-free (skim) milk		☐ Yes ☐ No
	Low-fat (1%) milk		
	Reduced-fat (2%) milk	14.	Are you on a diet now to lose weight or to
	Whole milk		maintain your weight?
	Flavored milk		☐ Yes ☐ No
	Cheese		
	Ice cream	15.	In the past year, have you tried to lose weight
	Yogurt		or control your weight by vomiting, taking diet
	Other milk and		pill or laxatives, or not eating?
	milk products:		☐ Yes ☐ No
Ma	al and Meal Alternatives		
	Beef/hamburger	16.	Did you participate in physical activity (for
	Chicken		example, walking or riding a bike) in the past
	Cold cuts/deli meals		week?
	Dried beans (for example, black		□ Yes □ No
	beans, kidney beans, pinto beans)		If yes, on how many days and for how many
	·		minutes or hours per day?
	Eggs Fish		
	Peanut butter/nuts	17.	Did you spend more than 2 hours per day
	Pork		watching television and DVDs or playing
			computer games?
	Sausage/bacon		□ Yes □ No
	Tofu		If yes, how many hours per day?
	Turkey		
	Other meal and	18.	Does the family watch television during
.	meat alternatives:		meals?
_	ts and Sweets		□ Yes □ No
	Cake/cupcakes		
	Candy	19.	
	Chips		dietary supplements (for example, protein
	French fries		powders)?
	Cookies		□ Yes □ No
	9		
		20.	,
			□ Yes □ No
		0.4	De view even use any of the following?
	Other fats and sweets:	21.	(Check all that apply)
11. D	o you have a working stove, oven,		☐ Alcohol, beer, or wine
ar	nd refrigerator where you live?		☐ Steroids (without a doctor's permission)
	Yes 🗆 No		Street drugs (marihuana, speed, crack, or heroin)

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 pa	aying attention? 🗌 Yes	□No					
To express strange thou		☐ No ☐ No ☐ No					
Grades?	s at school with: Yes Yes Yes	☐ No ☐ No ☐ No					
Sleep?	our child's:	☐ No ☐ No ☐ No					
Does your child often complain	n of "not feeling well"?	☐ No					
Does your child have trouble m	naking or keeping friends?	☐ No					
Angry?	Yes Yes Yes	☐ No ☐ No ☐ No					
Set fire?	Yes Yes	No					

Continued on back \longrightarrow

MARYLAND HEALTHY KIDS PROGRAM

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

Maryland Healthy Kids Program Page Two

Is there a history of injuries, accidents?
Is there any history of maltreatment or abuse?
Is there a recent stress on the family or child such as: Birth of a child
Do you have other parenting concerns?
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 Maryland Department of Health and Mental Hygiene HealthChoice and

Preve	entive Screen Questionr		D-4-	Date	Date	Date	Date
Lead Risk Assessment: (every well child visit from 6 months up to 6 years)	Date	Date	Date				
Has your child ever lived or stayed in a house or apartment that is built be (includes day care center, preschool home, home of babysitter or relative).	efore 1978 Y / N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
2. 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
3. Are there any current renovations or peeling paint in a home that your ch	ild regularly visits? Y / N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
 Does your child lick, eat, or chew things that are not food (paint chips, dir furniture, old toys, etc.)? 	t, railings, poles, Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
 Is there any family member who is currently working in an occupation or leading to the exposure could occur (auto mechanic, ceramics, commercial painter, etc.) 	hobby where lead Y/N c.)?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Tuberculosis Risk Assessment: (Starting at 1 month of age and annually thereafter)	Date	Date	Date	Date	Date	Date	Date
1. Has your child been exposed to anyone with a case of TB or a positive to	uberculin skin test? Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Was your child, or a household member, born in a high-risk country (cou the United States, Canada, Australia, New Zealand, or Western and Nor countries)?	ntries other than Y/N th European	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
 Has your child travelled (had a contact with resident populations) to a hig more than 1 week? 	h-risk country for 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., th infected, homeless, incarcerated, and/or illicit drug users)?	ose who are HIV 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
Anemia Screening	Date	Date	Date	Date	Date	Date	Date
(Starting at 11 years of age and annually thereafter)							
1. Does your diet include iron-rich foods such as meat, eggs, iron-fortified	cereals, or beans? Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Have you ever been diagnosed with iron deficiency anemia?	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
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
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

D -4!4 A1	Birth Date:
Patient Name:	

Preventive Screen Questionnaire **Date Date** Date Date Date Date Date Heart Disease/Cholesterol Risk Assessment: (2 years through 20 years) Y/N Y/N Y/N 1. Is there a family history of parents/grandparents under 55 years of age with a heart attack, Y/N Y/NY/N Y/Nheart surgery, angina or sudden cardiac death? Y/N Y/N Y/N Y/N2. Has the child's mother or father been diagnosed with high cholesterol (240 mg/dL or higher)? Y/NY/N Y/NY/N 3. Is the child/adolescent overweight (BMI > 85th %)? Y/N Y/N Y/N Y/NY/N Y/N4. And is there a personal history of: Y/N Y/N Y/N Y/N Y/NY/N Y/NSmoking? Y/N Y/N Y/NY/N Y/N Y/N Y/NLack of physical activity? Y/N Y/N Y/N Y/NY/N Y/NY/N High blood pressure? Y/N Y/N Y/N Y/N Y/NY/N Y/N High cholesterol? Y/N Y/N Y/N Y/N Y/N Diabetes mellitus? Y/N Y/N(Refer to the AAP Clinical Guidelines for Childhood Lipid Screening) Date STI/HIV Risk Assessment: **Date** Date Date Date Date Date (11 years through 20 years) Y/N Y/N Y/N Y/N Y/N Y/NY/N Have you had a blood transfusion or are you a Hemophiliac? Y/N Y/N Y/N Y/N Y/N Y/NY/NHave you ever been sexually molested or physically attacked? 2. Y/N Y/N Y/NY/N Y/N Y/N Y/N Have you ever been diagnosed with any sexually transmitted diseases? Y/N Y/N Y/NY/N Y/N Y/N Y/N Any history of IV drug use by you, your sex partner, or your birth mother during pregnancy? Y/N Y/N Y/NY/N Y/N Y/N Y/N If sexually active, have you had unprotected sex, with opposite/same sex? Y/N Y/N Y/N Y/N Y/N Y/NY/NIf sexually active, have you had more than one partner? Y/N Y/N Y/N Y/NY/NY/N Y/N

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

Any body tattoos or body piercing of ears, navel, etc., including any performed by friends?

Patient Name:	Birth Date:

MUTRITION QUESTIONNAIRE FOR ADOLESCENTS AGES IT TO 21 1. Which of these meals or snacks did you ☐ Tap or bottled water eat yesterday? ☐ Fitness water (Check all that apply) ☐ Juice ☐ Breakfast ☐ Regular soft drinks ☐ Lunch □ Diet soft drinks ☐ Dinner or supper ☐ Fruit-flavored drinks ☐ Morning snack □ Sport drinks ☐ Afternoon Snack □ Energy drinks ☐ Evening/late-snack □ Recovery drinks ☐ Fat-free (skim) milk 2. Do you skip breakfast 3 or more times a ☐ Low-fat (1%) milk week? ☐ Reduced-fat (2%) milk ☐ Yes □ No □ Whole milk Do you skip lunch 3 or more times a ☐ Flavored milk (for example, chocolate, week? strawberry) ☐ Yes □ No ☐ Coffee or tea Do you skip dinner or supper 3 or more ☐ Beer, wine, or hard liquor times a week? □ Yes □ No 10. Which of these foods did you eat last week? (Check all that apply) 3. Do you eat dinner or supper with your Grains: family 4 or more times a week? □ Bagels ☐ Yes □ No ☐ Bread □ Cereal/grits 4. Do you fix or buy the food for any of ☐ Crackers your family's meals? □ Muffins ☐ Yes ☐ No □ Noodles/pasta/rice ☐ Rolls 5. Do you eat or take out a meal from a □ Tortillas fast food restaurant 2 or more times a ☐ Other grains:..... week? **Vegetables** ☐ Yes □ No □ Broccoli □ Carrots 6. Are you on special diet for medical □ Corn reasons? ☐ Green beans ☐ Yes ☐ No ☐ Green salad ☐ Greens (collard, spinach) 7. Are you a vegetarian? ☐ Peas ☐ Yes □ No ☐ Potatoes □ Tomatoes 8. Do you have any problems with your ☐ Other vegetables..... appetite, like not feeling hungry, or **Fruits** feeling hungry all the time? ☐ Apples/ juice ☐ Yes □ No □ Bananas ☐ Grapefruit/juice

09/30/2014

Source: Bright Future Nutrition at http://www.brightfutures.org/nutrition/pdf/pocket.pdf

☐ Grapes/juice

9. Which of the following did you drink last

week?(Check all that apply)

☐ Melon	12.	Were there any days last month when your	
☐ Oranges/juice		family didn't have enough food to eat or	
☐ Peaches		enough money to buy food?	
☐ Pears		☐ Yes ☐ No	
☐ Other fruits/juice:			
Milk and Milk Products	13.	Are you concerned about your weight?	
□ Fat-free (skim) milk		☐ Yes ☐ No	
☐ Low-fat (1%) milk			
☐ Reduced-fat (2%) milk	14.	Are you on a diet now to lose weight or to	
☐ Whole milk		maintain your weight?	
☐ Flavored milk		☐ Yes ☐ No	
☐ Cheese			
☐ Ice cream	15.	In the past year, have you tried to lose weight	
☐ Yogurt		or control your weight by vomiting, taking diet	
☐ Other milk and		pill or laxatives, or not eating?	
milk products:		☐ Yes ☐ No	
Meal and Meal Alternatives			
☐ Beef/hamburger	16.	Did you participate in physical activity (for	
☐ Chicken		example, walking or riding a bike) in the past	
☐ Cold cuts/deli meals		week?	
□ Dried beans (for example, black		☐ Yes ☐ No	
beans, kidney beans, pinto beans)		If yes, on how many days and for how many	
□ Eggs		minutes or hours per day?	
☐ Fish			
☐ Peanut butter/nuts	17.	Did you spend more than 2 hours per day	
□ Pork		watching television and DVDs or playing	
☐ Sausage/bacon		computer games?	
☐ Tofu		☐ Yes ☐ No	
☐ Turkey		If yes, how many hours per day?	
☐ Other meal and	40	Door the family watch tolevision during	
meat alternatives:	18.	Does the family watch television during meals?	
Fats and Sweets		☐ Yes ☐ No	
☐ Cake/cupcakes		Lifes Lino	
☐ Candy	19.	Do you take vitamin, mineral, herbal, or other	
☐ Chips		dietary supplements (for example, protein	
☐ French fries		powders)?	
☐ Cookies		☐ Yes ☐ No	
□ Doughnuts		<u> </u>	
☐ Fruit-flavored drinks	20.	Do you smoke cigarettes or chew tobacco?	
☐ Pies		☐ Yes ☐ No	
☐ Soft drinks			
☐ Other fats and sweets:		Do you ever use any of the following? (Check all that apply)	
11. Do you have a working stove, oven,		☐ Alcohol, beer, or wine	
and refrigerator where you live?		☐ Steroids (without a doctor's permission)	
☐ Yes ☐ No		☐ Street drugs (marihuana, speed, crack, or heroin)	