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 paying attention? ......................... ☐ Yes ☐ No

Does your child often seem:
  Distrustful of others? .................................................. ☐ Yes ☐ No
  To express strange thoughts?................................. ☐ Yes ☐ No
  Blame others? .......................................................... ☐ Yes ☐ No

Does your child have problems at school with:
  Behavior?................................................................. ☐ Yes ☐ No
  Grades? ......................................................................... ☐ Yes ☐ No
  Skipping classes?....................................................... ☐ Yes ☐ No

Do you have concerns about your child's:
  Eating? ......................................................................... ☐ Yes ☐ No
  Sleep? ........................................................................... ☐ Yes ☐ No
  Weight? ............................................................................................................. ☐ Yes ☐ No

Does your child often complain of “not feeling well”? ..................... ☐ Yes ☐ No

Does your child have trouble making or keeping friends? ................. ☐ Yes ☐ No

Does your child often seem:
  Sad? ............................................................................. ☐ Yes ☐ No
  Angry?........................................................................... ☐ Yes ☐ No
  Nervous or afraid?......................................................... ☐ Yes ☐ No

Does your child show any of these behaviors?
  Destroy property? .............................................................. ☐ Yes ☐ No
  Set fire? ........................................................................... ☐ Yes ☐ No
  Lie? .................................................................................. ☐ Yes ☐ No
  Steal? ................................................................................... ☐ Yes ☐ No
  Listen to music with violent message? ....................... ☐ Yes ☐ No
  Hurt animal or smaller children? .............................. ☐ Yes ☐ No
  Use alcohol? ................................................................. ☐ Yes ☐ No
  Use drugs? ................................................................. ☐ Yes ☐ No
  Smoke cigarettes? ................................................................. ☐ Yes ☐ No
  Sexually active? ................................................................. ☐ Yes ☐ No

Continued on back →

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

https://mmcp.dhmh.maryland.gov/epsdt
MENTAL HEALTH QUESTIONNAIRE
Maryland Healthy Kids Program
Page Two

Is there a history of injuries, accidents? ........................................... □ Yes □ No
If yes, please specify: ___________________________________________

Is there any history of maltreatment or abuse? ................................. □ Yes □ No
If yes, please specify: ___________________________________________

Is there a recent stress on the family or child such as:
   Birth of a child .............................................................. □ Yes □ No
   Moving ........................................................................ □ Yes □ No
   Divorce or separation ....................................................... □ Yes □ No
   Death of a close relative .................................................. □ Yes □ No
   Fired or laid off .............................................................. □ Yes □ No
   Legal problems .............................................................. □ Yes □ No
   Others (Please specify): ___________________________________

Do you have other parenting concerns? ......................................... □ Yes □ No
Please specify: ________________________________________________

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

**Preventive Screen Questionnaire**

**Lead Risk Assessment:**
(every well child visit from 6 months up to 6 years)

<table>
<thead>
<tr>
<th></th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
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<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 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)?</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
</tr>
<tr>
<td>2. Is anyone in the home being treated or followed for lead poisoning?</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
</tr>
<tr>
<td>3. Are there any current renovations or peeling paint in a home that your child regularly visits?</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
</tr>
<tr>
<td>4. Does your child tick, eat, or chew things that are not food (paint chips, dirt, railings, poles, furniture, old toys, etc.)?</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
</tr>
<tr>
<td>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.)?</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
</tr>
</tbody>
</table>

**Tuberculosis Risk Assessment:**
(Starting at 1 month of age and annually thereafter)

<table>
<thead>
<tr>
<th></th>
<th>Date</th>
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<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Has your child been exposed to anyone with a case of TB or a positive tuberculin skin test?</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
</tr>
<tr>
<td>2. 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)?</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
</tr>
<tr>
<td>3. Has your child travelled (had a contact with resident populations) to a high-risk country for more than 1 week?</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
</tr>
<tr>
<td>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)?</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
</tr>
<tr>
<td>5. Does your child have HIV infection?</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
</tr>
</tbody>
</table>

**Anemia Screening**
(Starting at 11 years of age and annually thereafter)

<table>
<thead>
<tr>
<th></th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does your diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
</tr>
<tr>
<td>2. Have you ever been diagnosed with iron deficiency anemia?</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
</tr>
<tr>
<td>3. (FEMALES ONLY) Do you have excessive menstrual bleeding or other blood loss?</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
</tr>
<tr>
<td>4. (FEMALES ONLY) Does your period last more than 5 days?</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
</tr>
</tbody>
</table>

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

**Patient Name:**

**Birth Date:**

https://mmcp.dhmh.maryland.gov/epsdt/Pages/Home.aspx

Updated 2016
**MARYLAND HEALTHY KIDS PROGRAM**  
Preventive Screen Questionnaire

### Heart Disease/Cholesterol Risk Assessment:  
(2 years through 20 years)

<table>
<thead>
<tr>
<th>Question</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is there a family history of parents/grandparents under 55 years of age with a heart attack, heart surgery, angina or sudden cardiac death?</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
</tr>
<tr>
<td>2. Has the child's mother or father been diagnosed with high cholesterol (240 mg/dL or higher)?</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
</tr>
<tr>
<td>3. Is the child/adolescent overweight (BMI &gt; 85th %)?</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
</tr>
<tr>
<td>4. And is there a personal history of:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smoking?</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
</tr>
<tr>
<td>Lack of physical activity?</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
</tr>
<tr>
<td>High blood pressure?</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
</tr>
<tr>
<td>High cholesterol?</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
</tr>
<tr>
<td>Diabetes mellitus?</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
</tr>
</tbody>
</table>

*(Refer to the AAP Clinical Guidelines for Childhood Lipid Screening)*

### STI/HIV Risk Assessment:  
(11 years through 20 years)

<table>
<thead>
<tr>
<th>Question</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Have you had a blood transfusion or are you a Hemophiliac?</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
</tr>
<tr>
<td>2. Have you ever been sexually molested or physically attacked?</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
</tr>
<tr>
<td>3. Have you ever been diagnosed with any sexually transmitted diseases?</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
</tr>
<tr>
<td>4. Any history of IV drug use by you, your sex partner, or your birth mother during pregnancy?</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
</tr>
<tr>
<td>5. If sexually active, have you had unprotected sex, with opposite/same sex?</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
</tr>
<tr>
<td>6. If sexually active, have you had more than one partner?</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
</tr>
<tr>
<td>7. Any body tattoos or body piercing of ears, navel, etc., including any performed by friends?</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
<td>Y/N</td>
</tr>
</tbody>
</table>

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

**Patient Name:** ______________________________________________________  
**Birth Date:** ______________________________________________________

https://mmcp.dhmh.maryland.gov/epsdt/Pages/Home.aspx  
**Updated 2016**
1. Which of these meals or snacks did you eat yesterday?  
   (Check all that apply)  
   ☐ Breakfast  
   ☐ Lunch  
   ☐ Dinner or supper  
   ☐ Morning snack  
   ☐ Afternoon Snack  
   ☐ Evening/late-snack  

2. Do you skip breakfast 3 or more times a week?  
   ☐ Yes  ☐ No  
Do you skip lunch 3 or more times a week?  
   ☐ Yes  ☐ No  
Do you skip dinner or supper 3 or more times a week?  
   ☐ Yes  ☐ No  

3. Do you eat dinner or supper with your family 4 or more times a week?  
   ☐ Yes  ☐ No  

4. Do you fix or buy the food for any of your family's meals?  
   ☐ Yes  ☐ No  

5. Do you eat or take out a meal from a fast food restaurant 2 or more times a week?  
   ☐ Yes  ☐ No  

6. Are you on special diet for medical reasons?  
   ☐ Yes  ☐ No  

7. Are you a vegetarian?  
   ☐ Yes  ☐ No  

8. Do you have any problems with your appetite, like not feeling hungry, or feeling hungry all the time?  
   ☐ Yes  ☐ No  

9. Which of the following did you drink last week? (Check all that apply)  
   ☐ Tap or bottled water  
   ☐ Fitness water  
   ☐ Juice  
   ☐ Regular soft drinks  
   ☐ Diet soft drinks  
   ☐ Fruit-flavored drinks  
   ☐ Sport drinks  
   ☐ Energy drinks  
   ☐ Recovery drinks  
   ☐ Fat-free (skim) milk  
   ☐ Low-fat (1%) milk  
   ☐ Reduced-fat (2%) milk  
   ☐ Whole milk  
   ☐ Flavored milk (for example, chocolate, strawberry)  
   ☐ Coffee or tea  
   ☐ Beer, wine, or hard liquor  

10. Which of these foods did you eat last week? (Check all that apply)  
   Grains:  
   ☐ Bagels  
   ☐ Bread  
   ☐ Cereal grits  
   ☐ Crackers  
   ☐ Muffins  
   ☐ Noodles pasta rice  
   ☐ Rolls  
   ☐ Tortillas  
   ☐ Other grains:  
   Vegetables  
   ☐ Broccoli  
   ☐ Carrots  
   ☐ Corn  
   ☐ Green beans  
   ☐ Green salad  
   ☐ Greens (collard, spinach)  
   ☐ Peas  
   ☐ Potatoes  
   ☐ Tomatoes  
   ☐ Other vegetables:  
   Fruits  
   ☐ Apples juice  
   ☐ Bananas  
   ☐ Grapefruit juice  
   ☐ Grapes juice  

---

09/30/2014  
12. Were there any days last month when your family didn’t have enough food to eat or enough money to buy food?
☐ Yes  ☐ No

13. Are you concerned about your weight?
☐ Yes  ☐ No

14. Are you on a diet now to lose weight or to maintain your weight?
☐ Yes  ☐ No

15. In the past year, have you tried to lose weight or control your weight by vomiting, taking diet pill or laxatives, or not eating?
☐ Yes  ☐ No

16. Did you participate in physical activity (for example, walking or riding a bike) in the past week?
☐ Yes  ☐ No
If yes, on how many days and for how many minutes or hours per day?.........................

17. Did you spend more than 2 hours per day watching television and DVDs or playing computer games?
☐ Yes  ☐ No
If yes, how many hours per day?....................

18. Does the family watch television during meals?
☐ Yes  ☐ No

19. Do you take vitamin, mineral, herbal, or other dietary supplements (for example, protein powders)?
☐ Yes  ☐ No

20. Do you smoke cigarettes or chew tobacco?
☐ Yes  ☐ No

21. Do you ever use any of the following? (Check all that apply)
☐ Alcohol, beer, or wine
☐ Steroids (without a doctor’s permission)
☐ Street drugs (marijuana, speed, crack, or heroin)