State of Illinois
Illinois Department of Public Health

Public Health Nurse Form for Lead Assessment

Date: _____

Child's Name:

Last: _____

First: _____

Date of Birth: _____ ☐ Male ☐ Female

Ethnicity: _____

Medicaid Number: _____

Parent's/Guardian's Name:

Last: _____

First: _____

Home Phone: _____ Cell Phone: _____

Address: _____

Apt.: _____ City: _____

ZIP Code: _____ County: _____

How long at this address?

Years: _____ Months: _____ ☐ Rent ☐ Own

Landlord's Address: _____

Landlord's Phone: _____

Previous Address: _____

☐ Rent ☐ Own

Has your child lived/traveled outside of the US in the last year?

☐ Yes ☐ No

If yes, length of time/location: _____

Does the Child spend time at:

☐ Home ☐ Daycare/babysitter ☐ Preschool

☐ School ☐ Relative/friend/neighbor

List address where time is spent if other than home:

_____

Physician's Name:

Last: _____

First: _____

Nurse Contact: _____

Address: _____

Phone: _____

Blood Lead Test Date: _____

Venous Test Result: ____ µg/dL Next Test Date: _____

A. FAMILY ASSESSMENT

1. Number of children in household: _____

Name	DOB	Relationship	Lead Test

2. Parent's Occupation/Hobbies:

Mother: _____

Father: _____

3. Are there any pregnant women in the household?

☐ Yes ☐ No

a. Have the pregnant women been tested for lead?

☐ Yes ☐ No

Result of lead test _____

Reason for testing _____

b. Has educational material been given to the pregnant women?

☐ Yes ☐ No

c. Occupation: _____

Hobby: _____

4. What does the parent/guardian think may be the source of the lead exposure?

_____

B. CHILD'S HEALTH STATUS AND HISTORY

C. REVIEW OF SYMPTOMS

1. Abdominal Pain?	☐ Yes ☐ No	Duration:	
2. Constipation?	☐ Yes ☐ No	Duration:	
3. Vomiting?	☐ Yes ☐ No	Duration:	
4. Extreme activity?	☐ Yes ☐ No	Duration:	
5. Sleeps Frequently?	☐ Yes ☐ No	Duration:	
6. Irritability?	☐ Yes ☐ No	Duration:	

Other: _____

D. DEVELOPMENTAL DELAYS

Gross Motor? _____

Fine Motor? _____

Social Skills? _____

Speech? _____

Previous testing/evaluation? _____

Developmental Screening performed? ☐ Yes ☐ No

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E. ORAL TENDENCIES

1. Has the child been observed mouthing or eating non-food substances? ☐ Yes ☐ No
2. What does the child put in his/her mouth?
   ☐ Hands ☐ Windowsills ☐ Magazines
   ☐ Toys ☐ Newspapers ☐ Furniture
   ☐ Dirt ☐ Railings/Moldings ☐ Doors
   Other: _____
3. How often does the child put his/her hands or other objects in his/her mouth?
   ☐ Never/Rarely ☐ Sometimes ☐ Often/Frequently
4. Is the child a thumb/finger sucker? ☐ Yes ☐ No
   Bite Nails? ☐ Yes ☐ No
5. Does the child use a pacifier? ☐ Yes ☐ No

F. SLEEPING AREA

1. Is there loose paint on nearby walls or the ceiling that could fall into the child's crib/bed? ☐ Yes ☐ No
2. Does the crib, bed, furniture, or windowsills show any teeth marks? ☐ Yes ☐ No
3. Is the child's crib/bed near a window exposed to inside/ outside sources of lead? ☐ Yes ☐ No

G. FOOD PREPARATION AND EATING AREA

1. Is any paint peeling from ceilings or walls in the food preparation or eating area? ☐ Yes ☐ No
2. Are there any windows or doors in the food preparation area that could create lead dust? ☐ Yes ☐ No
3. Do you use hot tap water when preparing food or bottles? ☐ Yes ☐ No
4. Do you prepare or store food in or eat food from cans or pottery? ☐ Yes ☐ No
5. Do you use glazed dishes or dishes made outside the United States? ☐ Yes ☐ No

H. EATING HABITS

1. Is your child enrolled in the Women, Infant, Children (WIC program)? ☐ Yes ☐ No
2. How many meals and snacks per day does your child eat?

   _____
3. Does your child eat daily sources of fruits and vegetables? ☐ Yes ☐ No
4. Does your child eat daily sources of meat/eggs/dried beans? ☐ Yes ☐ No

H. EATING HABITS (cont.)

5. Does your child sources of calcium such as milk/yogurt/ cheese? ☐ Yes ☐ No
   How many ounces consumed: _____
6. Does your child use a bottle? ☐ Yes ☐ No
7. Does your child breastfeed? ☐ Yes ☐ No
8. Do you use bottled water to prepare formula or other drinks for you child? ☐ Yes ☐ No
9. Does your child take a vitamin with iron or other supplements every day? ☐ Yes ☐ No
10. Do you have any food, candy, spices, supplements, or home remedies that have been bought or packaged in another country? ☐ Yes ☐ No

I. PLAY HABITS AND ENVIRONMENTAL SAFETY

1. Does your child hide or play quietly? ☐ Yes ☐ No
   If yes, where? _____
2. Where else inside the house does your child play?

   _____
3. Where does your child play outside?

   _____
4. Does your child play in the basement? ☐ Yes ☐ No
5. Does your child play on the porch? ☐ Yes ☐ No
6. Do you have pets? ☐ Yes ☐ No
   If yes, do they come inside the home? ☐ Yes ☐ No
7. Is there a garage/outbuilding on the property? ☐ Yes ☐ No
8. Are there mini-blinds in the sleep or play area? ☐ Yes ☐ No
9. Does your child play at the window? ☐ Yes ☐ No
10. Does your child play with any painted or metal toys, antique toys, or toy jewelry? ☐ Yes ☐ No
11. Has your child been seen chewing or sucking on key chains, necklaces, or metal jewelry? ☐ Yes ☐ No
12. What is your child's favorite toy or item they are seen playing with often?

    _____

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I. PLAY HABITS AND ENVIRONMENTAL SAFETY (cont.)

13. Do you use any cosmetics/make-up on your child?
☐ Yes ☐ No

If yes, What do you use and was it bought from outside the United States?

_____

J. OBSERVATION OF DWELLING UNIT

1. Exterior construction:
☐ Painted ☐ Brick ☐ Siding Other: _____
2. Is paint peeling or chipping from walls or ceiling?
☐ Yes ☐ No
If yes, where? _____
3. Is the house in a high traffic area or near an industry (i.e. foundry, lead smelter, battery recycling facility)?
☐ Yes ☐ No
4. Are renovations occurring? ☐ Yes ☐ No
If yes, location in home:

_____
5. Have you removed any wall paper or carpet from your home?
☐ Yes ☐ No
6. Housekeeping practices:
☐ Good ☐ Moderate ☐ Poor
7. Overall condition of the house:
☐ Good ☐ Moderate ☐ Poor
8. Age of windows: _____

COMMENTS

_____
Staff conducting home visit

_____
Nurse signature

_____
Today's Date

_____
Date of environmental inspection referral