

Pediatric Environmental History (0-18 Years of Age)

Additional Categories and Questions to Supplement The Screening Environmental History

For all of the questions below, most are often asked about the child's primary residence. Although some questions may specify certain locations, one should always consider all places where the child spends time, such as daycare centers, schools, and relative's houses.

General Housing Characteristics (For lead poisoning, refer to Table 3.2 in Managing Elevated Blood Lead Levels Among Young Children)

Do you own or rent your home?	_____
What year was your home built? (Or: Was your home built before 1978? 1950?)	_____
Has your child been tested for lead?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
Is there a family member or playmate with an elevated blood lead level?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
Does your child spend significant time at another location? (e.g. baby sitters, school, daycare?)	_____

Indoor home environment (For asthma, refer to Environmental History Form for Pediatric Asthma Patient)

If a family member smokes, does this person want to quit smoking?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
Is your child exposed to smoke at the baby sitters, school, or daycare center?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
Do regular visitors to your home smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
Have there been renovations or new carpet or furniture in the home during the past year?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
Does your home have carpet?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
Is the room where your child sleeps carpeted?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
Do you use a wood stove or fire place?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
Have you had water damage, leaks, or a flood in your home?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
Do you see cockroaches in your home daily or weekly?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
Do you see rats and/or mice in your home weekly?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
Do you have smoke detectors in your home?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure

Air Pollution/Outdoor Environment (For asthma, refer to Environmental History Form for Pediatric Asthma Patient)

Is your home near an industrial site, hazardous waste site, or landfill?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
Is your home near major highways or other high traffic roads?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
Are you aware of Air Quality Alerts in your community?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
Do you change your child's activity when an Air Quality Alert is issued?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure
Do you live on or near a farm where pesticides are used frequently?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure

Food and Water Contamination

If you use well water for drinking, when was the last time the water was tested?

Coliform bacteria_____ Other microbials_____ Nitrites/nitrates_____ Arsenic_____ Pesticides_____

For all types of water sources:

Have you tested your water for lead?

Yes No Not sure

Do you mix infant formula with tap water?

Yes No Not sure

Which types of seafood do you normally eat? _____

How many times per month do you eat that particular fish or shellfish? _____

How many times a week do you eat any of the following types of fish?

Shark_____ Swordfish_____ Tile fish_____ King mackerel_____ Albacore tuna_____ Other_____

How often do you wash fruits and vegetables before giving them to your child? _____

What type of produce do you buy? Organic Local Grocery store Other

Toxic Chemical Exposures (Also refer to Taking an Environmental History and Environmental and Occupational History in Recognition and Management of Pesticide Poisonings)

Consider this set of questions for patients with seizures, frequent headaches, or other unusual or chronic symptoms

How often are pesticides applied inside your home? _____

How often are pesticides applied outside your home? _____

Where do you store chemicals/pesticides? _____

Do you often use solvents or other cleaning or disinfectant chemicals? _____

Do you have a deck or play structure made from pressure treated wood? _____

Yes No Not sure

Have you applied a sealant to the wood in the past year? _____

Yes No Not sure

What do you use to prevent mosquito bites to your children? _____

How often do you apply that product? _____

Occupations and Hobbies

What type of work does your child/teenager do? _____

Do any adults work around toxic chemicals? _____

Yes No Not sure

If so, do they shower and change clothes before returning home from work? _____

Yes No Not sure

Does the child or any family member have arts, crafts, ceramics, stained glass work or similar hobbies? _____

Yes No Not sure

Health Related Questions

Have you ever relocated due to concerns about an environmental exposure? _____

Yes No Not sure

Do symptoms seem to occur at the same time of day? _____

Yes No Not sure

Do symptoms seem to occur after being at the same place every day? _____

Yes No Not sure

Do symptoms seem to occur during a certain season? _____

Yes No Not sure

Are family members/neighbors/co-workers experiencing similar symptoms? _____

Yes No Not sure

Are there environmental concerns in your neighborhood, child's school, or day care? _____

Yes No Not sure

Has any family member had a diagnosis of any of the following?

Asthma Autism Cancer Learning disability

Does your child suffer from any of the following recurrent symptoms? _____

Cough Headaches Fatigue Unexplained pain_____

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