Communicable Disease Epidemiology Section
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Follow Up Lead Exposure Questionnaire

Date: _____

This questionnaire serves as a tool to show that appropriate control measures have been implemented per ARM 37.114.501. **The Montana Department of Public Health and Human Services requests this questionnaire be entered in MIDIS or faxed to the CD Epidemiology Section at 1-800-616-7460.**

Patient's Name (First, Last, MI): _____DOB: _____Sex (F, M) _____
Race (Circle all that apply): AI/AN Asian Black White NHPI Ethnicity Latino/Hispanic? (Circle one) Yes or No
Residential Address (physical): _____City: _____ State: ____ Zip Code: _____

Ordering Physician Contacted?	Yes	No	Unknown	Date Completed: _____
If "Yes," re-testing has been scheduled.	Yes	No	Unknown	Date Completed: _____

If the patient is a child, do they attend a daycare?	Yes	No	Unknown
Is the patient enrolled in Medicaid?	Yes	No	Unknown
Is the patient a recipient of Women, Infants, and Children (WIC) Program Services?	Yes	No	Unknown
Has the patient been placed in your home through the foster care system?	Yes	No	Unknown
Does the patient live in or visit a home, daycare or other building built before 1978 with peeling or chipping paint, or with recent or ongoing renovation or remodeling?	Yes	No	Unknown
Does the patient live in a rental property?	Yes	No	Unknown
Do you live (or previously lived) in assisted housing or received any financial assistance for housing? (ex. Housing Choice Voucher, Project-Based Section 8, Public Housing)?	Yes	No	Unknown
Does the patient eat or chew on non-food items such as paint chips or dirt?	Yes	No	Unknown
Is there a family member/friend who ever had an elevated blood level?	Yes	No	Unknown
Should other household members be tested for elevated blood lead?	Yes	No	Unknown

Additional people in the home that could be at risk _____

Is the patient a refugee, immigrant, or adopted from another country? Yes No Unknown
Country of Origin: _____ Country of last residence (if different): _____

Is the patient exposed to contamination from a parent, relative or friend with jobs or hobbies such as any of these? Please check all that apply.

- ○ Pottery making
- ○ Lead smelting
- ○ Welding
- ○ Making fishing weights
- ○ House construction or repair
- ○ Batteries
- ○ Lead-painted wood
- ○ Automotive repair
- ○ Going to a firing range or reloading bullets
- ○ Chemical preparation
- ○ Valve and pipe fittings
- ○ Brass/copper foundry
- ○ Refinishing furniture

Is the patient exposed to sources of lead in any of the following sources listed below? Please check all that apply.

- ○ Drinking water (pre-1986 household plumbing/fixtures, components of older private wells, >20 yrs.)
- ○ Imported or glazed pottery
- ○ Spices, candy, and other foods canned or packaged outside of the United States
- ○ Traditional remedies or nutritional supplements other than vitamins

Potential lead exposures not already indicated: _____

_____

If the exposure was identified through occupational medical monitoring, indicate the following:
Industry (e.g. mining) _____ Occupation (e.g. electrician) _____
Employer_____ Employer Contact Information _____