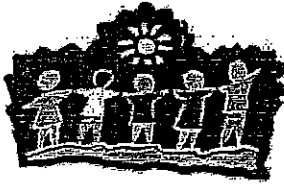


East Cobb Pediatrics & Adolescent Medicine, P.C.

Marisa R. Gadea, M.D.
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Karen Thrower, M.D.
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Tracy Barr, M.D.
Laura Badwan, M.D.
Sharon Lebedin, NP
Barbara Cossman, NP
Shelly Brown, NP

Georgia Healthy Homes and Lead Poisoning Prevention Program

Patients Name _____ Date of Birth _____

Risk Factors Assessment Questionnaire

1. Does your child live in or often visit a house that may have been built before 1978?
2. Does your child live in or often visit a house, built before 1978, that is being remodeled or is having paint removed?
3. Does your child live with or often visit another child that had or has an elevated blood lead level?
4. Does your child live with anyone that works at a job where lead may be found or has a hobby that uses lead?
5. Does your child chew on or eat non-food items like paint chips or dirt?
6. Does your child live near an active lead smelter, battery recycling plant, or other industry likely to release lead?
7. Does your child receive medicines such as greta, azarcon, kohl, or pay-loo-ah?

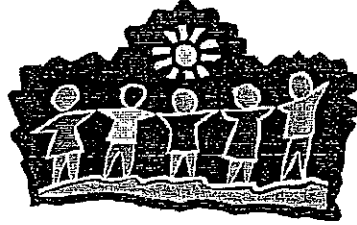
When using the questionnaire, blood lead tests should be done immediately if the child is at high risk (one or more "yes" or "I don't know" answers on the risk assessment questionnaire) for lead exposure.

Marietta: 1121 Johnson Ferry Road, Suite 220, Marietta, GA 30068 ph: 770-977-0094 fax: 770-509-9463
Kennesaw: 6110 Pine Mountain Road, Suite 202, Kennesaw, GA 30152 ph: 770-795-4553 fax: 770-795-4513

Visit us on the web: www.eastcobbped.com

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Parent Instructions for PEDS Form

- This form is a Parent's Evaluation of Developmental Status and helps to ensure that your child is progressing appropriately for their age.
- On the first question, please list any concerns that you have about your child. If you have no concerns, please write that on the form.
- For the remaining questions, answer *yes* or *A little* if you have the concern now or have had it in the past, even if it has improved. Please comment what the concern is or was.
- Answer *No* to the following questions if you have never had a concern about that question.
- Once completed, please give this form to the medical assistant or nurse that takes you back to the clinical area. If you have any questions, they will be happy to help you.

Thank you for completing the form.

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PEDS RESPONSE FORM

Provider _____

Child's Name _____ Parent's Name _____

Child's Birthday _____ Child's Age _____ Today's Date _____

Please list any concerns about your child's learning, development, and behavior.

Do you have any concerns about how your child talks and makes speech sounds?

Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child understands what you say?

Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child uses his or her hands and fingers to do things?

Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child uses his or her arms and legs?

Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child behaves?

Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child gets along with others?

Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child is learning to do things for himself/herself?

Circle one: No Yes A little COMMENTS:

Do you have any concerns about how your child is learning preschool or school skills?

Circle one: No Yes A little COMMENTS:

Please list any other concerns.