

**New Jersey Department of Health and Senior Services
Child and Adolescent Health Program
PO Box 364
Trenton, NJ 08625-0364**

**HAZARD ASSESSMENT QUESTIONNAIRE
FOR INVESTIGATION OF CHILDREN WITH ELEVATED BLOOD LEAD LEVELS**

Name(s) of Individual(s) Administering Questionnaire (<i>Print</i>)	Title(s)
Signature(s)	Date of Completion

The results of this questionnaire will be used for two purposes:

- To determine where environmental samples should be collected.
- To develop corrective measures related to use patterns and living characteristics (e.g., flushing the water line if water lead levels are high, increase cleanliness of dwelling).

The administrator(s) of this questionnaire should always recommend temporary measures to immediately reduce the child's exposure to lead hazards.

GENERAL INFORMATION		
Dwelling Address	Apt. #	Floor #
Where do you think the child is exposed to the lead hazard? [<i>Specify location(s)</i>]:		
Do you rent or own your home? <input type="checkbox"/> Rent <input type="checkbox"/> Own		
If rent, does the family receive any rent subsidies? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, what type <input type="checkbox"/> Public Housing Authority – Name of housing authority: _____ <input type="checkbox"/> Section 8 <input type="checkbox"/> Federal rent subsidy <input type="checkbox"/> Other: _____		
Landlord Information (or Rent Collector Agent) <i>(Include all means of contacting the property owner, including fax number, email address, cell phone/beeper number)</i> Name: _____ Address: _____ Telephone Number: _____ Fax Number: _____ Cell Phone/Beeper Number: _____ Email Address: _____		
In what country was the child born? <input type="checkbox"/> USA <input type="checkbox"/> US Territory (Puerto Rico, U.S. Virgin Islands, Guam, American Samoa, etc.) <input type="checkbox"/> Other: _____ <input type="checkbox"/> Don't know <input type="checkbox"/> Decline to answer		

**HAZARD ASSESSMENT QUESTIONNAIRE
(Continued)**

Complete the following for all addresses where the child currently lives and has lived during the past three (3) months.

Dates of Residency (MM/YYYY to MM/YYYY)	Street Address, City, State	Year Dwelling Built	Single Family or Multi Unit	General Condition of Dwelling	Any Remodeling or Renovation? (Yes or No)	Any Deteriorated Paint? (Yes or No)

Complete the following for all addresses where the child currently or has been cared for, away from home, during the past three (3) months.

Dates of Care (MM/YYYY to MM/YYYY)	Type of Care*	Name of Contact, Street Address, City, State, Telephone Number	Number of Hours Per Week	General Condition of Structure	Any Remodeling or Renovation? (Yes or No)	Any Deteriorated Paint? (Yes or No)

**Type of care includes: preschool, child care center, child care home, care provided by a relative or friend.*

Complete the following for all times the child spent outside of the US. This includes any traveling, visiting family or friends, or living in another country. Start with the most recent.

#	Country	When did child stay there (start with most recent)? (Month/Year)	How long did child stay?		Comments
			Weeks	Months	
1					
2					
3					

Lead-Based Paint and Lead-Contaminated Dust Hazards

Approximately what year was this dwelling built? _____

To your knowledge, has this dwelling ever been tested for lead-based paint or lead-contaminated dust?
 Yes No

If Yes, when and from whom can this information be obtained? _____

To your knowledge, has there been any recent repainting, remodeling, renovation, window replacement, sanding, or scraping of painted surfaces inside or outside this dwelling unit?
 Yes No

If Yes, when and from whom can this information be obtained? _____

**HAZARD ASSESSMENT QUESTIONNAIRE
(Continued)**

Lead in Soil Hazards, Continued		
c.	Is the dwelling located within two blocks of a major roadway, freeway, elevated highway, or other transportation structures?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If Yes, specify: _____	
d.	Are nearby buildings or structures being renovated, repainted or demolished?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If Yes, location: _____	
e.	Is there deteriorated paint on porches, fences, garages, play structures, railings, building siding, windows, trims, or mailboxes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If Yes, location(s): _____	
f.	Was gasoline or other solvents ever used to clean parts or disposed of at the property?	<input type="checkbox"/> Yes <input type="checkbox"/> No
g.	Are there visible paint chips near the perimeter of the house, fences, garages, or play structures?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If Yes, location(s): _____	
h.	Has the soil ever been tested for lead?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If Yes, from whom can this information be obtained? _____	
i.	Have you burned painted wood in a woodstove or fireplace?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If Yes, have you emptied ashes onto soil? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	If Yes, location: _____	

Occupational/Hobby Lead Hazards	
Occupations and hobbies that may cause lead exposure include the following:	
<ul style="list-style-type: none"> • Paint removal (including sandblasting, scraping, abrasive blasting, sanding, or using a heat gun or torch) • Working in a chemical plant, a glass factory, an oil refinery, or any other work involving lead • Remodeling, repairing, or renovating dwellings or buildings, or tearing down buildings or metal structures (demolition) • Creating explosives or ammunition • Plumbing • Repairing radiators • Making batteries • Chemical strippers • Melting metal for reuse (smelting) 	<ul style="list-style-type: none"> • Welding, burning, cutting, or torch work • Making paint or pigments • Auto body repair work • Pouring molten metal (foundries) • Salvaging metal or batteries • Working at a firing range • Making or repairing jewelry • Making or splicing cable or wire • Building, repairing, or painting ships • Painting • Making pottery

Where do adult family members work (include mother, father, older siblings, other adult household members)?		
Name	Place of Employment	Occupation or Job Title

**HAZARD ASSESSMENT QUESTIONNAIRE
(Continued)**

Occupational/Hobby Lead Hazards, Continued			Comments
1.	Are work clothes washed with other laundry?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
2.	Has anyone in the household removed paint or varnish while in the dwelling? (paint removal from woodwork, furniture, cars, bicycles, boats)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
3.	Has anyone in the household soldered electric parts while at home?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
4.	Does anyone in the household apply glaze to ceramic or pottery objects?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
5.	Does anyone in the household work with stained glass?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
6.	Does anyone in the household use artist paints to paint pictures or jewelry?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
7.	Does anyone in the household reload bullets, target shoot, or hunt?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
8.	Does anyone in the household melt lead to make bullets or fishing sinkers?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
9.	Does anyone in the household work in auto body repair at home or in the yard?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
10.	Is there evidence of take-home work exposures or hobby exposures in the dwelling?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

Child Behavior Risk Factors			Comments
1.	Does child suck his/her fingers?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
2.	Does child put painted objects into his/her mouth? (If Yes, specify under Comments)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
3.	Does child chew on painted surfaces, such as old painted cribs, window sills, furniture edges, railings, door molding, or broom handles? (If Yes, specify under Comments)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
4.	Does child chew on putty around windows?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
5.	Does child put soft metal objects in his/her mouth (lead and pewter toys and toy soldiers, jewelry, gunshot, bullets, beads, fishing sinkers, or any items containing solder)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
6.	Does child chew or eat paint chips or pick at painted surfaces?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
7.	Is the paint deteriorated in the child's play areas?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
8.	Does the child put foreign-printed material (newspapers, magazines) in his/her mouth?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
9.	Does the child put matches in his/her mouth?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
10.	Does the child play with cosmetics, hair preparations, or talcum powder or put them into his/her mouth?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
	a. If yes, are any of these foreign made?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
11.	Does the child have a favorite cup? (If Yes, specify under Comments)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

**HAZARD ASSESSMENT QUESTIONNAIRE
(Continued)**

Child Behavior Risk Factors, Continued	
12. Does the child have a favorite eating utensil? (If Yes, specify under Comments)	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
13. Does the family have a dog, cat, or other pet that could track in contaminated soil or dust from the outside?	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
a. If yes, where does the pet sleep?	_____
14. Does the child take baths in an old bathtub with deteriorated or nonexistent glazing?	<input type="checkbox"/> Yes <input type="checkbox"/> No _____

Other Household Risk Factors

Complete the table below for the following imported products used by, used on or given to the child during the past 12 months.

Sources can include products:

- sent/given to you by friends and/or family
- bought in local stores
- brought back from trips you may have taken
- prescribed by alternative medicine practitioner

Product Type	Used		Product Name	Country of Origin	Comments <i>(include form of the product such as powder, pill, used as a tea)</i>
	Yes	No			
Cosmetics (including kohl, surma, ceruse)					
Home remedies/folk medicines (including teething, colic, fever, stomachaches or diarrhea)					
Alternative medicine or herbal treatments					
Ayurvedic medicines (based on traditional Asian Indian medical system)					
Vitamins					
Liquids prepared, served and/or stored in metal, pewter, glazed, soldered, or crystal containers					
Foods prepared, served, and/or stored in metal, pewter, glazed, soldered, or crystal containers					
Deodorant (i.e., litargirio)					
Spices					
Snacks or candies (including candy spiced with chili, tamarind, sold in clay pots)					

**HAZARD ASSESSMENT QUESTIONNAIRE
(Continued)**

Other Household Risk Factors, Continued

Does the child play in, live in, or have access to any areas where the following materials are kept?

Item	Yes	No		Yes	No		Yes	No
Shellacs			Epoxy Resins			Gasoline		
Lacquers			Putty			Paints		
Driers			Industrial Crayons or Markers			Old Batteries		
Coloring Pigments			Fishing Sinkers			Battery Casings		
Pipe Sealants			Solder			Lead Pellets		
Drapery Weights			Fungicides			Pesticides		
Detergents			Gear Oil			Gasoline		

Does the child eat, chew on, or put other non-food items into his/her mouth (i.e., toys, mini-blinds, crayons, candy wrappers, jewelry)?

#	Item Name/Description	Country of Manufacturer	How Often?
1			_____ times per _____
2			_____ times per _____
3			_____ times per _____
4			_____ times per _____

Assessment of Hazard Control Measures

What cleaning equipment does the family have in the dwelling?
 Broom Mop and Bucket Vacuum (Does it work? Yes No) Sponges and Rags

Room	Type of Floor Covering [vinyl/linoleum, carpeting, wood, other (specify)]	Smooth and Cleanable (Yes or No)	Type of Cleaning (sweep, wet mop, vacuum)	Frequency of Cleaning (daily, weekly, monthly)	General Cleanliness *
Entry/foyer					
Living Room					
Dining Room					
Kitchen					
Child's Bedroom					
Bathroom					

* General cleanliness of the dwelling interior:
 1 = appears clean 2 = some evidence of housecleaning 3 = no evidence of housecleaning

How frequently are window sills cleaned? How frequently are window troughs cleaned?