

Pediatric Environmental Home Assessment

Last updated 6/7/06

RESIDENT REPORTED INFORMATION

Bolded responses indicate areas of greater concern.

General Housing Characteristics

Type of ownership	<input type="checkbox"/> Own house	<input type="checkbox"/> Market rate rental hsg.	<input type="checkbox"/> Subsidized rental hsg.	<input type="checkbox"/> Shelter	
Age of home	<input type="checkbox"/> Pre-1950	<input type="checkbox"/> 1950 - 1978	<input type="checkbox"/> Post-1978	<input type="checkbox"/> Don't know	
Structural foundation	<input type="checkbox"/> Basement	<input type="checkbox"/> Slab on grade	<input type="checkbox"/> Crawlspace	<input type="checkbox"/> Don't know	
Floors lived in (check all that apply)	<input type="checkbox"/> Basement	<input type="checkbox"/> 1 st	<input type="checkbox"/> 2 nd	<input type="checkbox"/> 3 rd or higher	
Heating	Fuel used	<input type="checkbox"/> Natural gas	<input type="checkbox"/> Oil	<input type="checkbox"/> Electric	<input type="checkbox"/> Wood
	Sources in home	<input type="checkbox"/> Baseboards	<input type="checkbox"/> Radiators	<input type="checkbox"/> Forced hot air vents	<input type="checkbox"/> Other: _____
	Filters changed	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> HEPA air filter	<input type="checkbox"/> Don't know
	Control	<input type="checkbox"/> Easy to control heat	<input type="checkbox"/> Hard to control heat		
Cooling	<input type="checkbox"/> Windows	<input type="checkbox"/> Central/window AC	<input type="checkbox"/> Fans	<input type="checkbox"/> None	
Ventilation (check all that apply)	<input type="checkbox"/> Open windows	<input type="checkbox"/> Kitchen & bathroom fans	<input type="checkbox"/> Central ventilation		

Indoor Pollutants

Mold and moisture	<input type="checkbox"/> Uses dehumidifier <input type="checkbox"/> No damage	<input type="checkbox"/> Uses vaporizer or humidifier	<input type="checkbox"/> Musty odor evident	<input type="checkbox"/> Visible water / mold damage	
Pet	Presence	<input type="checkbox"/> No pets	<input type="checkbox"/> Cat # _____	<input type="checkbox"/> Dog # _____	<input type="checkbox"/> Other: _____
	Management	<input type="checkbox"/> Kept strictly outdoors	<input type="checkbox"/> Not allowed in patient's bedroom	<input type="checkbox"/> Full access in home	<input type="checkbox"/> Sleeping location: _____
Pests	Cockroaches	<input type="checkbox"/> None	<input type="checkbox"/> Family reports	<input type="checkbox"/> Family shows evidence	Present in <input type="checkbox"/> kitchen <input type="checkbox"/> bedroom <input type="checkbox"/> other
	Mice	<input type="checkbox"/> None	<input type="checkbox"/> Family reports	<input type="checkbox"/> Family shows evidence	Present in <input type="checkbox"/> kitchen <input type="checkbox"/> bedroom <input type="checkbox"/> other
	Rats	<input type="checkbox"/> None	<input type="checkbox"/> Family reports	<input type="checkbox"/> Family shows evidence	Present in <input type="checkbox"/> kitchen <input type="checkbox"/> bedroom <input type="checkbox"/> other
	Bedbugs	<input type="checkbox"/> None	<input type="checkbox"/> Family reports	<input type="checkbox"/> Family shows evidence	Present in <input type="checkbox"/> bedroom <input type="checkbox"/> other
Lead paint hazards	<input type="checkbox"/> Tested and passed	<input type="checkbox"/> Tested, failed, and mitigated	<input type="checkbox"/> Not tested/Don't know	<input type="checkbox"/> Loose, peeling, or chipping, paint	
Asbestos	<input type="checkbox"/> Tested – None present	<input type="checkbox"/> Tested, failed, and mitigated	<input type="checkbox"/> Not tested/Don't know	<input type="checkbox"/> Damaged material	
Radon	<input type="checkbox"/> Tested and passed	<input type="checkbox"/> Tested, failed, and mitigated	<input type="checkbox"/> Not tested/Don't know	<input type="checkbox"/> Failed test but not mitigated	
Health and Safety Alarms	<input type="checkbox"/> Smoke alarm working and well placed	<input type="checkbox"/> CO alarm working and one on each floor	<input type="checkbox"/> CO alarm does not log peak level	<input type="checkbox"/> No smoke alarm <input type="checkbox"/> No CO alarm	
Tobacco smoke exposure	<input type="checkbox"/> No smoking allowed	<input type="checkbox"/> Smoking only allowed outdoors	<input type="checkbox"/> Smoking allowed indoors <input type="checkbox"/> bedroom <input type="checkbox"/> playroom	<input type="checkbox"/> Total # smokers in household: _____ <input type="checkbox"/> Mother smokes	
Other irritants	<input type="checkbox"/> None	<input type="checkbox"/> Air fresheners	<input type="checkbox"/> Potpourri, incense, candles	<input type="checkbox"/> Other strong odors: _____	
Type of cleaning	<input type="checkbox"/> Vacuum (non-HEPA)	<input type="checkbox"/> HEPA vacuum	<input type="checkbox"/> Damp mop and damp dusting	<input type="checkbox"/> Sweep or dry mop	

NOTES:

NURSE OBSERVED INFORMATION

Bolded responses indicate areas of greater concern.

Home Environment					
Drinking Water Source		<input type="checkbox"/> Public water system	<input type="checkbox"/> Household Well		
Kitchen	Cleanliness	<input type="checkbox"/> No soiling	<input type="checkbox"/> Trash or garbage sealed	<input type="checkbox"/> Trash or garbage not sealed	<input type="checkbox"/> Wall/ceiling/floor damage
	Ventilation	<input type="checkbox"/> Functioning stove exhaust fan/vent	<input type="checkbox"/> Mold growth present	<input type="checkbox"/> Broken stove exhaust fan/vent	<input type="checkbox"/> No stove exhaust fan/vent
Bathroom		<input type="checkbox"/> Functioning exhaust fan/vent/window	<input type="checkbox"/> Mold growth present	<input type="checkbox"/> Needs cleaning and maintenance	<input type="checkbox"/> Wall/ceiling/floor damage
Basement		<input type="checkbox"/> None/No Access	<input type="checkbox"/> Mold growth present	<input type="checkbox"/> Needs cleaning and maintenance	<input type="checkbox"/> Wall/ceiling/floor damage
Living Room		<input type="checkbox"/> No soiling	<input type="checkbox"/> Mold growth present	<input type="checkbox"/> Needs cleaning and maintenance	<input type="checkbox"/> Wall/ceiling/floor damage
Laundry area		<input type="checkbox"/> None	<input type="checkbox"/> Well maintained	<input type="checkbox"/> Dryer not vented	<input type="checkbox"/> Hang clothes to dry

Sleep Environment				
Patient's sleep area	<input type="checkbox"/> Own room	<input type="checkbox"/> Shared # in room _____	<input type="checkbox"/> Other	
# Beds	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> More than 2
Allergen impermeable encasings on beds	<input type="checkbox"/> On mattress and boxspring (zippered)	<input type="checkbox"/> On mattress only (zippered)	<input type="checkbox"/> On mattress (not zippered)	<input type="checkbox"/> No mattress covers
Pillows	<input type="checkbox"/> Allergen-proof	<input type="checkbox"/> Washable	<input type="checkbox"/> Feather/ down	
Bedding	<input type="checkbox"/> Washable	<input type="checkbox"/> Wool/not washable	<input type="checkbox"/> Feather/ down	
Flooring	<input type="checkbox"/> Hardwood/Tile/Linoleum	<input type="checkbox"/> Small area rug	<input type="checkbox"/> Large area rug	<input type="checkbox"/> Wall-to-wall carpet
Dust/mold catchers	<input type="checkbox"/> Stuffed animals/washable toys <input type="checkbox"/> No clutter	<input type="checkbox"/> Non-washable toys	<input type="checkbox"/> Plants	<input type="checkbox"/> Other _____
Window	<input type="checkbox"/> Washable shades/curtains	<input type="checkbox"/> Washable blinds	<input type="checkbox"/> Curtains/ drapes	<input type="checkbox"/> No window/poor ventilation
Other irritants	<input type="checkbox"/> Abundant cosmetics and fragrances			

Home Safety <i>* can indicate housing code violations</i>				
General				
Active renovation or remodeling	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
*Stairs, protective walls, railings, porches	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
*Hallway lighting	<input type="checkbox"/> Adequate	<input type="checkbox"/> Inadequate		
Poison control number	<input type="checkbox"/> Posted by phone	<input type="checkbox"/> Not posted by phone		
**Family fire escape plan	<input type="checkbox"/> Developed and have copy available	<input type="checkbox"/> None		
Electrical appliances (radio, hair dryer, space heater)	<input type="checkbox"/> Not used near water	<input type="checkbox"/> Used near water		
Matches and lighters stored	<input type="checkbox"/> Out of child's reach	<input type="checkbox"/> Within child's reach		
Exterior environment	<input type="checkbox"/> Well maintained	<input type="checkbox"/> Abundant trash and debris	<input type="checkbox"/> Chipping, peeling paint	<input type="checkbox"/> Broken window(s)

NURSE OBSERVED INFORMATION (continued)


Home Safety

** can indicate housing code violations*


Young Children Present	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Coffee, hot liquids, and foods	<input type="checkbox"/> Out of child's reach	<input type="checkbox"/> Within child's reach	
Cleaning supplies stored	<input type="checkbox"/> Out of child's reach	<input type="checkbox"/> Within child's reach	
Medicine and vitamins stored	<input type="checkbox"/> Out of child's reach	<input type="checkbox"/> Within child's reach	
Child (less than six years old) been tested for lead poisoning	<input type="checkbox"/> Within past 6 months Result: _____	<input type="checkbox"/> Within past year or more. When? _____ Result: _____	<input type="checkbox"/> No
Child watched by an adult while in the tub	<input type="checkbox"/> Always	<input type="checkbox"/> Most of the time	<input type="checkbox"/> No
*Home's hot water temperature	<input type="checkbox"/> <120 F	<input type="checkbox"/> >120 F	<input type="checkbox"/> Don't know
Non-accordion toddler gates used	<input type="checkbox"/> At top of stairs	<input type="checkbox"/> At bottom of stairs	<input type="checkbox"/> No
Crib mattress	<input type="checkbox"/> Fits well	<input type="checkbox"/> Loose	<input type="checkbox"/> NA
Window guards	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Window blind cords	<input type="checkbox"/> Split cord	<input type="checkbox"/> Looped cord	

NOTES:

Funded by The U.S. Environmental Protection Agency



and developed by



National Center for Healthy Housing

10227 Wincopin Circle, Suite 200 • Columbia, MD 21044 • Tel. (410) 992-0712
www.centerforhealthyhousing.org

With thanks to

N • E • E • T • F

The National Environmental Education & Training Foundation

We credit its *Environmental Management of Pediatric Asthma: Guidelines for Health Care Providers* and model Pediatric Environmental History Form

and



The Center for Healthy Homes and Neighborhoods at Boston University

We credit its model Pediatric Asthma-Allergy Home Assessment form