HealthPartners

Lead Questionnaire

Yes	No	
☐	☐	**1. Have you ever had your blood tested for lead?** If yes, have you ever been told that your blood lead level was too high? ☐ Yes ☐ No When was your last test? _____
		2. Do you have any of the following symptoms?
☐	☐	Metallic taste in mouth
☐	☐	Frequent heartburn
☐	☐	Frequent stomach pain
☐	☐	Bouts of “appendicitis”
☐	☐	Loss of control of your bowels
☐	☐	Loss of control of your bladder
☐	☐	Trouble urinating
☐	☐	Irritability
☐	☐	Restlessness
☐	☐	Fatigue (feeling tired most of the time)
☐	☐	Feeling depressed
☐	☐	Feeling unable to cope
☐	☐	Muscle pain
☐	☐	Joint pain
☐	☐	Joint swelling
☐	☐	Lapses in memory
☐	☐	Weakness
☐	☐	Confusion
☐	☐	Poor coordination
☐	☐	Handwriting changes
☐	☐	Trouble walking
☐	☐	Dizziness
☐	☐	Tremor
☐	☐	Infertility