factors for lead intoxication include living in older homes with cracked or peeling lead-based paint, industrial exposure, use of foreign remedies (e.g., a diarrhea remedy from Central or South America), and use of pottery with lead paint glaze. Because of the significant association of lead intoxication with poverty, the CDC recommends blood lead screening at 12 and 24 months. In addition, standardized screening questions for risk of lead intoxication should be asked for all children between 6 months and 6 years of age (Table 9-2). Any positive or suspect response is an indication for obtaining a blood lead level. Capillary blood sampling may produce false-positive results, thus, a venous blood sample should be obtained. County health departments, community organizations, and private companies provide lead inspection and detection services to determine the source of the lead. Standard decontamination techniques should be used to remove the lead while avoiding aerosolizing the toxic metal that a child might breathe or creating dust that a child might ingest (see Chapters 149 and 150).

Tuberculosis Testing

The prevalence of tuberculosis is increasing, largely as a result of the adult human immunodeficiency virus (HIV) epidemic. Children often present with serious and multisystem disease (miliary tuberculosis). All children should be assessed for risk of tuberculosis at health maintenance visits, especially after 1 year of age. The high-risk groups, as defined by the CDC, are listed in Table 9-3. In general the standardized purified protein derivative intradermal test is used with evaluation by a health care provider 48 to 72 hours after injection. The size of induration, not the color of any mark, denotes a positive test. For most patients, 10 mm of induration is a positive test. For HIV-positive patients, those with recent tuberculosis contacts, patients with evidence of old healed tuberculosis on chest film, or immunosuppressed patients, 5 mm is a positive test (see Chapter 124). The CDC has approved (in adults) the QuantiFERON-TB Gold Test, which has the advantage of needing one office visit only.

Table 9-2 Lead Poisoning Risk Assessment Questions to be Asked between 6 Months and 6 Years

Does the child spend any time in a building built before 1960 (e.g., home, school, barn) that has cracked or peeling paint?
Is there a brother, sister, housemate, playmate, or community member being followed or treated (or even rumored to be) for lead poisoning?
Does the child live with an adult whose job or hobby involves exposure to lead (e.g., lead smelting and automotive radiator repair)?
Does the child live near an active lead smelter, battery recycling plant, or other industry likely to release lead?
Does the family use home remedies or pottery from another country?

Table 9-3 Groups at High Risk for Tuberculosis

Close contact with persons known to have tuberculosis (TB), positive TB test, or suspected to have TB
Foreign-born persons from areas with high TB rates (Asia, Africa, Latin America, Eastern Europe, Russia)
Health care workers
High-risk racial or ethnic minorities or other populations at higher risk (Asian, Pacific Islander, Hispanic, African American, Native American, groups living in poverty [e.g., Medicaid recipients], migrant farm workers, homeless persons, substance abusers)
Infants, children, and adolescents exposed to adults in high-risk categories

Cholesterol

Children and adolescents who have a family history of cardiovascular disease or have at least one parent with a high blood cholesterol level are at increased risk of having high blood cholesterol levels as adults and increased risk of coronary heart disease. The American Academy of Pediatrics (AAP) recommends dyslipidemia screening in the context of regular health care for at-risk populations (Table 9-4) by obtaining a fasting lipid profile. The recommended screening levels are the same for all children 2 to 18 years. Total cholesterol of less than 170 mg/dL is normal, 170 to 199 mg/dL is borderline, and greater than 200 mg/dL is elevated. In addition, in 2011, the AAP endorsed the National Heart, Lung, and Blood Institute of the National Institutes of Health recommendation to test all children between ages 9 and 11.

Sexually Transmitted Infection Testing

Annual office visits are recommended for adolescents. A full adolescent psychosocial history should be obtained in confidential fashion (see Section 12). Part of this evaluation is a comprehensive sexual history that often requires creative questioning. Not all adolescents identify oral sex as sex, and some adolescents misinterpret the term *sexually active* to mean that one has many sexual partners or is very vigorous during intercourse. The questions, "Are you having sex?" and "Have you ever had sex?" should be asked. In the Bright Futures guidelines, any child or adolescent who has had any form of sexual intercourse should have at least an annual evaluation (more often if there is a history of high-risk sex) for sexually transmitted diseases by physical examination (genital warts, genital herpes, and pediculosis) and laboratory testing (chlamydia, gonorrhea, syphilis, and HIV) (see Chapter 116). Young women should be assessed for human papillomavirus and precancerous lesions by Papanicolaou smear at 21 years of age.

IMMUNIZATIONS

Immunization records should be checked at each office visit, regardless of the reason. Appropriate vaccinations should be administered (see Chapter 94).

Table 9-4 Cholesterol Risk Screening Recommendations

Risk screening at ages 2, 4, 6, 8, 10 and annually in adolescence:
1. Children and adolescents who have a family history of high cholesterol or heart disease
2. Children whose family history is unknown
3. Children who have other personal risk factors: obesity, high blood pressure, or diabetes
Universal screening at ages 9–11 and ages 18–20