CLEAR FORM

PATIENT NAME: _____ DATE: _____

Please print.

American Academy of Pediatrics

BRIGHT FUTURES PREVISIT QUESTIONNAIRE

12 MONTH VISIT

Bright Futures™

To provide you and your child with the best possible health care, we would like to know how things are going. Please answer all the questions. Thank you.

WHAT WOULD YOU LIKE TO TALK ABOUT TODAY?

Do you have any concerns, questions, or problems that you would like to discuss today? ○ **No** ○ **Yes,** describe:

TELL US ABOUT YOUR CHILD AND FAMILY.

What excites or delights you most about your child?

Does your child have special health care needs? ○ **No** ○ **Yes,** describe:

Have there been major changes lately in your child's or family's life? ○ **No** ○ **Yes,** describe:

Have any of your child's relatives developed new medical problems since your last visit? ○ **No** ○ **Yes** ○ **Unsure** If yes or unsure, please describe:

Does your child live with anyone who smokes or spend time in places where people smoke or use e-cigarettes? ○ **No** ○ **Yes** ○ **Unsure**

YOUR GROWING AND DEVELOPING CHILD

Do you have specific concerns about your child's development, learning, or behavior? ○ **No** ○ **Yes,** describe:

Check off each of the tasks that your child is able to do.

- ☐ Look for hidden objects.
- ☐ Imitate new gestures.
- ☐ Say, "Dad" or "Mom" with meaning
- ☐ Use one word other than *Mom*, *Dad*, or personal names.
- ☐ Follow a verbal command that includes a gesture.
- ☐ Take first independent steps.
- ☐ Stand without support.
- ☐ Drop objects in a cup.
- ☐ Pick up small object with 2-finger pincer grasp.
- ☐ Pick up food and eat it.

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RISK ASSESSMENT

Hearing	Do you have concerns about how your child hears?	O No	O Yes	O Unsure
	Do you have concerns about how your child speaks?	O No	O Yes	O Unsure
Lead	Does your child live in or visit a home or child care facility with an identified lead hazard or a home built before 1960 that is in poor repair or that was renovated in the past 6 months?	O No	O Yes	O Unsure
Oral health	Does your child's primary water source contain fluoride?	O Yes	O No	O Unsure
Tuberculosis	Was your child or any household member born in, or has he or she traveled to, a country where tuberculosis is common (this includes countries in Africa, Asia, Latin America, and Eastern Europe)?	O No	O Yes	O Unsure
	Has your child had close contact with a person who has tuberculosis disease or who has had a positive tuberculosis test result?	O No	O Yes	O Unsure
	Is your child infected with HIV?	O No	O Yes	O Unsure
Vision	Do you have concerns about how your child sees?	O No	O Yes	O Unsure
	Do your child's eyes appear unusual or seem to cross?	O No	O Yes	O Unsure
	Do your child's eyelids droop or does one eyelid tend to close?	O No	O Yes	O Unsure
	Have your child's eyes ever been injured?	O No	O Yes	O Unsure

ANTICIPATORY GUIDANCE

How are things going for you, your child, and your family?

YOUR FAMILY'S HEALTH AND WELL-BEING

Living Situation and Food Security		
Do you have enough heat, hot water, electricity, and working appliances in your home?	O Yes	O No
Do you have problems with bugs, rodents, peeling paint or plaster, mold, or dampness?	O No	O Yes
Within the past 12 months, were you ever worried whether your food would run out before you got money to buy more?	O No	O Yes
Within the past 12 months, did the food you bought not last, and you did not have money to get more?	O No	O Yes
Alcohol and Drugs		
Does anyone in your household drink beer, wine, or liquor?	O No	O Yes
Do you or other family members use marijuana, cocaine, pain pills, narcotics, or other controlled substances?	O No	O Yes
Social Connections With Family, Friends, Child Care, Home Visitation Program Staff, and Others		
Do you have child care or an adult you trust to care for your child?	O Yes	O No
Have you talked about your thoughts on feeding, sleeping, discipline, and media use with your caregiver?	O Yes	O No
Do you participate in activities outside your home? These may be social, religious, volunteer, or recreational programs.	O Yes	O No

CARING FOR YOUR CHILD

If your child is upset, do you help distract him using another activity, book, or toy?	O Yes	O No
Do you use time-outs as a way to manage your child's behavior?	O Yes	O No
Do you have any questions about what to do when you become angry or frustrated with your child?	O No	O Yes
Does your family regularly make time for reading, playing, and talking together?	O Yes	O No
Do you eat together as a family?	O Yes	O No
Do you have regular mealtimes and snack times?	O Yes	O No
Do you help your child feel comfortable around new people and new situations?	O Yes	O No
Do you have regular nap time and bedtime routines for your child, such as reading books and brushing teeth?	O Yes	O No

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CARING FOR YOUR CHILD (*CONTINUED*)

Does your child watch TV or play on a tablet or smartphone? If yes, how much time each day? ____ hours	O No	O Yes
Have you made a family media use plan to help you balance media use with other family activities?	O Yes	O No

FEEDING YOUR CHILD

Does your child try feeding herself using a spoon?	O Yes	O No
Does your child drink from a cup?	O Yes	O No
Do you give your child small, hard foods such as peanuts and popcorn?	O No	O Yes
Do you give your child round foods such as hot dogs, raw carrots, grapes, and grape tomatoes?	O No	O Yes
Do you include your child in family meals?	O Yes	O No
Have you begun to serve your child cow's milk?	O Yes	O No
Does your child eat vegetables and fruits?	O Yes	O No
Does your child eat foods rich in protein, such as eggs, lean meat, chicken, or fish?	O Yes	O No
Do you let your child decide what and how much to eat?	O Yes	O No

HEALTHY TEETH

Do you brush your child's teeth with a smear of fluoridated toothpaste 2 times a day using a soft toothbrush?	O Yes	O No

SAFETY

Car and Home Safety			
Is your child fastened securely in a rear-facing car safety seat in the back seat every time he rides in a vehicle?		O Yes	O No
Are you having any problems using your car safety seat?		O No	O Yes
Do you have a gate at the top and bottom of all stairs in your home?		O Yes	O No
Is the mattress in your child's crib set on the lowest setting to prevent falls?		O Yes	O No
Do you keep household cleaners, chemicals, and medicines locked up and out of your child's sight and reach?		O Yes	O No
Do all your electrical outlets have covers?		O Yes	O No
Do you keep sharp objects, plastic bags, and electrical or drapery cords out of your child's reach?		O Yes	O No
Do you keep your child away from the stove, fireplaces, and space heaters?		O Yes	O No
Are your TVs, bookcases, and dressers secured to the wall so they cannot fall over and hurt your child?		O Yes	O No
Water and Sun Safety			
Do you always stay within arm's reach of your child when he is in the bath?		O Yes	O No
Do you have a swimming pool, pond, or lake in or near your home?		O No	O Yes
Do you put a hat on your child and apply sunscreen on her when you go outside?		O Yes	O No
Pets			
Do you own a pet?		O No	O Yes
If so, does your child interact with the pet?	O NA	O No	O Yes

Consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents,* 4th Edition

For more information, go to https://brightfutures.aap.org.

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DEDICATED TO THE HEALTH OF ALL CHILDREN®