

American Academy of Pediatrics



BRIGHT FUTURES PREVISIT QUESTIONNAIRE

4 YEAR VISIT

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:

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TELL US ABOUT YOUR CHILD AND FAMILY.

What excites or delights you most about your child?

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

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

Blank area for text input.

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

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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:

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

- | | | |
|--|---|---|
| <input type="checkbox"/> Go to the bathroom and have a bowel movement by himself. | <input type="checkbox"/> Speak so strangers can understand 100% of what she says. | <input type="checkbox"/> Climb stairs, using one foot, then the other, without support. |
| <input type="checkbox"/> Dress and undress without much help. | <input type="checkbox"/> Draw pictures you recognize. | <input type="checkbox"/> Draw a person with at least 3 body parts. |
| <input type="checkbox"/> Play make-believe. | <input type="checkbox"/> Follow simple rules when playing board or card games. | <input type="checkbox"/> Draw a simple cross. |
| <input type="checkbox"/> Answer questions such as "What do you do when you are cold?" and "When you are sleepy?" | <input type="checkbox"/> Tell you a story from a book. | <input type="checkbox"/> Unbutton and button medium-sized buttons. |
| <input type="checkbox"/> Use 4-word sentences. | <input type="checkbox"/> Skip on one foot. | <input type="checkbox"/> Grasp a pencil with a thumb and fingers instead of her fist. |

Please print.

4 YEAR VISIT

RISK ASSESSMENT

Anemia	Does your child's diet include iron-rich foods, such as meat, iron-fortified cereals, or beans?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unsure
	Do you ever struggle to put food on the table?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
Dyslipidemia	Does your child have parents, grandparents, or aunts or uncles who have had a stroke or heart problem before age 55 (male) or 65 (female)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Does your child have a parent with elevated blood cholesterol level (240 mg/dL or higher) or who is taking cholesterol medication?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> 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 was renovated in the past 6 months?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
Oral health	Does your child have a dentist?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unsure
	Does your child's primary water source contain fluoride?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> 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)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Has your child had close contact with a person who has tuberculosis disease or who has had a positive tuberculosis test result?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Is your child infected with HIV?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> 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		
Is permanent housing a worry for you?	<input type="radio"/> No	<input type="radio"/> Yes
Do you have enough heat, hot water, electricity, and working appliances?	<input type="radio"/> Yes	<input type="radio"/> No
Within the past 12 months, were you ever worried whether your food would run out before you got money to buy more?	<input type="radio"/> No	<input type="radio"/> Yes
Within the past 12 months, did the food you bought not last, and you did not have money to get more?	<input type="radio"/> No	<input type="radio"/> Yes
Alcohol and Drugs		
Does anyone in your household drink beer, wine, or liquor?	<input type="radio"/> No	<input type="radio"/> Yes
Do you or other family members use marijuana, cocaine, pain pills, narcotics, or other controlled substances?	<input type="radio"/> No	<input type="radio"/> Yes
Intimate Partner Violence		
Do you always feel safe in your home?	<input type="radio"/> Yes	<input type="radio"/> No
Has your partner, or another significant person in your life, ever hit, kicked, or shoved you, or physically hurt you or your child?	<input type="radio"/> No	<input type="radio"/> Yes
Safety in the Community		
Do you feel safe in your community?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have someone you can turn to if you are concerned about your child's safety?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have connections to your community through faith groups, volunteer organizations, or recreational programs?	<input type="radio"/> Yes	<input type="radio"/> No
Do you spend time with parents of other children in your community?	<input type="radio"/> Yes	<input type="radio"/> No

GETTING READY FOR SCHOOL

Language Understanding and Fluency		
Does your child clearly communicate his wants and needs to you and others?	<input type="radio"/> Yes	<input type="radio"/> No
Do you respond to your child's questions with short and simple answers?	<input type="radio"/> Yes	<input type="radio"/> No
Do you give your child plenty of time to tell a story or answer a question?	<input type="radio"/> Yes	<input type="radio"/> No
Do you talk, sing, and read together every day?	<input type="radio"/> Yes	<input type="radio"/> No

4 YEAR VISIT

GETTING READY FOR SCHOOL (CONTINUED)

Feelings		
Is your child generally happy and active?	<input type="radio"/> Yes	<input type="radio"/> No
Do you help your child say, "I'm sorry," for hurting others' feelings?	<input type="radio"/> Yes	<input type="radio"/> No
Opportunities to Socialize With Other Children		
Is your child interested in other children?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child have a chance to play with other children in playgroups or at preschool?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child have a best friend?	<input type="radio"/> Yes	<input type="radio"/> No
Do you praise your child when she is good or has finished a task?	<input type="radio"/> Yes	<input type="radio"/> No
Early Childhood Programs and Preschool		
Does your child attend preschool?	<input type="radio"/> Yes	<input type="radio"/> No
Are you happy with your child care or preschool arrangement?	<input type="radio"/> Yes	<input type="radio"/> No
Do you visit your child's preschool and participate in activities there?	<input type="radio"/> Yes	<input type="radio"/> No
Readiness for School		
Do you have any concerns about your child starting school in the coming year?	<input type="radio"/> No	<input type="radio"/> Yes
Are you doing things to get your child ready for preschool? This could include reading together and going to the library, the park, the zoo, and other places.	<input type="radio"/> Yes	<input type="radio"/> No

HEALTHY HABITS

Nutrition		
Does your child drink water every day?	<input type="radio"/> Yes	<input type="radio"/> No
How many ounces of milk does your child drink on most days?	_____ oz	
Do you offer your child a variety of foods, including vegetables, fruits, and foods rich in protein, such as meat, eggs, chicken, or fish?	<input type="radio"/> Yes	<input type="radio"/> No
Is your child willing to try new flavors and food textures?	<input type="radio"/> Yes	<input type="radio"/> No
Do you let your child decide how much to eat and when to stop?	<input type="radio"/> Yes	<input type="radio"/> No
Daily Routines That Promote Health		
Does your child sleep well?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have a regular bedtime and mealtime routines?	<input type="radio"/> Yes	<input type="radio"/> No
Do you brush your child's teeth twice a day with a pea-sized amount of fluoridated toothpaste?	<input type="radio"/> Yes	<input type="radio"/> No

LIMITING TV AND PROMOTING PHYSICAL ACTIVITY

How much time every day does your child spend watching TV or using computers, tablets, or smartphones?	_____ hours	
Does your child have a TV or an Internet-connected device in her bedroom?	<input type="radio"/> No	<input type="radio"/> Yes
Has your family made a media use plan to help everyone balance time spent on media with other family and personal activities?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child play actively for at least 1 hour a day?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child play with other children?	<input type="radio"/> Yes	<input type="radio"/> No
Are you physically active together as a family, such as going for walks or playing in the park?	<input type="radio"/> Yes	<input type="radio"/> No

SAFETY

Car Safety		
Is your child fastened securely in a car safety seat or belt-positioning booster seat in the back seat every time he rides in a vehicle?	<input type="radio"/> Yes	<input type="radio"/> No
Does everyone else in the vehicle always use a lap and shoulder seat belt, booster seat, or car safety seat?	<input type="radio"/> Yes	<input type="radio"/> No

Please print.

4 YEAR VISIT

SAFETY (CONTINUED)

Outdoor Safety		
Do you watch your child closely when she plays outside, especially near streets and driveways?	<input type="radio"/> Yes	<input type="radio"/> No
Are there swimming pools in your neighborhood?	<input type="radio"/> No	<input type="radio"/> Yes
Are you planning to have your child learn to swim?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child always wear an US Coast Guard–approved life jacket when on a boat?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child always use sunscreen when he plays outside?	<input type="radio"/> Yes	<input type="radio"/> No
Pets		
Do you own a pet?	<input type="radio"/> No	<input type="radio"/> Yes
Have you taught your child how to behave around animals so she does not get bitten or scratched?	<input type="radio"/> Yes	<input type="radio"/> No
Gun Safety		
Does anyone in your home or the homes where your child spends time have a gun?	<input type="radio"/> No	<input type="radio"/> Yes
If yes, is the gun unloaded and locked up?	<input type="radio"/> Yes	<input type="radio"/> No
If yes, is the ammunition stored and locked up separately from the gun?	<input type="radio"/> Yes	<input type="radio"/> No

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

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

