

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

Please print.

American Academy of Pediatrics



## BRIGHT FUTURES PREVISIT QUESTIONNAIRE

# 11 THROUGH 14 YEAR VISITS FOR PARENTS

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 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

Check off all the items that you feel are true for your child.

- |  |   |
|--|---|
| <input type="checkbox"/> My child does things that help her have a healthy lifestyle, such as eating healthy foods, being physically active, and keeping herself safe. | <input type="checkbox"/> My child helps others by himself or by working with a group in school, a faith-based organization, or the community. |
| <input type="checkbox"/> My child has at least one adult in his life who cares about him and knows he can go to if he needs help.                                      | <input type="checkbox"/> My child is able to bounce back when things don't go her way.  |
| <input type="checkbox"/> My child has at least one friend or a group of friends who she feels comfortable around.  | <input type="checkbox"/> My child feels hopeful and self-confident.   |
|  | <input type="checkbox"/> My child is becoming more independent and making more decisions on his own as he gets older.                         |

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DATE: \_\_\_\_\_

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## 11 THROUGH 14 YEAR VISITS FOR PARENTS

### RISK ASSESSMENT

<b>Anemia</b>	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
	Has your child ever been diagnosed with iron deficiency anemia?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Does your family ever struggle to put food on the table?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	<b>If your child is female</b> , does she have excessive menstrual bleeding or other blood loss?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	<b>If your child is female</b> , does her period last more than 5 days?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
<b>Dyslipidemia</b>	Does your child have parents, grandparents, or aunts or uncles who have had a stroke or heart problem before age 55 (males) or 65 (females)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Does your child have a parent with an 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
<b>Hearing</b>	Do you have concerns about how your child hears?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
<b>Oral health</b>	Does your child's primary water source contain fluoride?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unsure
<b>Sexually transmitted infections/ HIV</b>	Adolescents who are sexually active are at risk of sexually transmitted infection, including HIV. Adolescents who use injection drugs are at risk of HIV. Are you concerned that your young adolescent might be at risk?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
<b>Tuberculosis</b>	Is your child infected with HIV?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	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
<b>Vision</b>	Do you have concerns about how your child sees?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Does your child have trouble with near or far vision?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Has your child ever failed a school vision screening test?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Does your child tend to squint?	<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

<b>Interpersonal Violence (Fighting and Bullying)</b>			
Are there frequent reports of violence in your community or school?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Is your child involved in any of the violence?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Do you think your child is safe in the neighborhood?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Has your child ever been injured in a fight?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Has your child been bullied or hurt by others?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Has your child bullied or been aggressive toward others?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Have you talked with your child about violence in dating situations and how to be safe?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
<b>Living Situation and Food Security</b>			
Do you have concerns about your living situation?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Do you have enough heat, hot water, and electricity?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you have appliances that work?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you have problems with bugs, rodents, or peeling paint or plaster?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
In the past 12 months, did you worry that your food would run out before you got money to buy more?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
In the past 12 months, did the food you bought not last, and you did not have money to buy more?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes

Please print.

## 11 THROUGH 14 YEAR VISITS FOR PARENTS

### YOUR FAMILY'S HEALTH AND WELL-BEING (CONTINUED)

Alcohol and Drugs			
Is there anyone in your child's life whose alcohol or drug use concerns you?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Connectedness With Family and Peers			
Does your family get along well with each other?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you take time to talk with your child every day?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Does your family do things together?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Does your child have chores or responsibilities at home?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you have clear rules and expectations for your child?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you let your child know when he does something good?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Connectedness With Community			
Does your child have interests outside of school?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Does your child help others at home, in school, or in your community?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
School Performance			
Is your child getting to school on time?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Is your child having any problems at school?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Does your child complete homework on time?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Has your child missed more than 2 days of school in any month?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Coping With Stress and Decision-making			
Does your child worry too much or appear overly anxious?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Have you discussed ways to deal with stress?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you help your child make decisions and solve problems?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No

### YOUR GROWING AND CHANGING CHILD

Healthy Teeth			
Does your child see the dentist regularly?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you have trouble getting dental care?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Body Image			
Do you have any concerns about your child's nutrition, weight, or physical activity?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Does your child talk about getting fat or dieting to lose weight?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Healthy Eating			
Do you think your child eats healthy foods?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you have any difficulty getting healthy food for your family?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Do you have any concerns about your child's eating habits or nutrition?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Do you eat meals together as a family?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Physical Activity and Sleep			
Is your child physically active at least 1 hour a day? This includes running, playing sports, or doing physically active things with friends.	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Are there opportunities to safely play outside in your neighborhood?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you and your child participate in physical activities together?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
How much time does your child spend on recreational screen time each day?	_____ hours		
Does your child have a TV, computer, tablet, or smartphone in his bedroom?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Do you have rules about screen time for your child?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Has your family made a family media use plan to help everyone balance time spent on media with other family and personal activities?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Does your child have a regular bedtime?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No

Please print.

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### YOUR CHILD'S EMOTIONAL WELL-BEING

Mood and Mental Health			
Is your child frequently irritable?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Have you noticed any changes in your child's weight or sleep habits?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Do you and your child often have conflicts about what your culture expects for her behavior and how her friends behave?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Do you have any concerns about your child's emotional health, such as being frequently sad or depressed?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Sexuality			
Have you and your child talked about how his body will change during puberty?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you have house rules about curfews, dating, and friends?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No

### HEALTHY BEHAVIOR CHOICES

Sexual Activity			
Have you and your child talked about sex?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Have you talked about ways to deal with any pressures to have sex?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Substance Use			
Have you talked with your child about alcohol and drug use?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you know your child's friends?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you know where your child is and what she does after school and on the weekends?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you have consequences for your child if you discover he is using tobacco, alcohol, or drugs?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
To your knowledge, is your child currently using alcohol or drugs, or has she used them in the past?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
Acoustic Trauma			
Does your child often listen to loud music?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes

### SAFETY

Seat Belt and Helmet Use			
Do you always wear a lap and shoulder seat belt and bicycle helmet?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you insist your child wears a lap and shoulder seat belt when in a car?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Do you insist that your child use a life jacket when he does water sports?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Sun Protection			
Does your child use sunscreen?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Gun Safety			
Is there a gun in your home or the homes where your child visits?	<input type="radio"/> No	<input type="radio"/> Sometimes	<input type="radio"/> Yes
If yes, is the gun unloaded and locked up?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
If yes, is the ammunition stored and locked up separately from the gun?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<input type="radio"/> No
Have you talked with your child about gun safety?	<input type="radio"/> Yes	<input type="radio"/> Sometimes	<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>.

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®



The information contained in this questionnaire should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances. Original questionnaire included as part of the *Bright Futures Tool and Resource Kit, 2nd Edition*.

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