CLEAR FORM

PATIENT NAME: _____ DATE: _____

Please print.

American Academy of Pediatrics

BRIGHT FUTURES PREVISIT QUESTIONNAIRE

2 YEAR 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. **Autism Spectrum Disorder screening is also part of this visit.** 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.

- ☐ Play with other children and express interest in their play.
- ☐ Take off some clothing.
- ☐ Scoop well with a spoon.
- ☐ Use 50 words.
- ☐ Combine 2 words into a short phrase or sentence.
- ☐ Follow a 2-step command (such as "Pick it up and put it away").
- ☐ Name at least 5 body parts.
- ☐ Speak so strangers can understand 50% of what he says.
- ☐ Kick a ball.
- ☐ Jump off the ground with 2 feet.
- ☐ Run with coordination.
- ☐ Climb up a ladder at a playground.
- ☐ Stack objects.
- ☐ Turn book pages.
- ☐ Use his hands to turn objects.
- ☐ Draw lines.

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RISK ASSESSMENT

Anemia	Does your child's diet include iron-rich foods, such as meat, iron-fortified cereals, or beans?	○ Yes	○ No	○ Unsure
	Do you ever struggle to put food on the table?	○ No	○ Yes	○ 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)?	○ No	○ Yes	○ Unsure
	Does your child have a parent with elevated blood cholesterol level (240 mg/dL or higher) or who is taking cholesterol medication?	○ No	○ Yes	○ Unsure
Hearing	Do you have concerns about how your child hears?	○ No	○ Yes	○ Unsure
	Do you have concerns about how your child speaks?	○ No	○ Yes	○ 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?	○ No	○ Yes	○ Unsure
Oral health	Does your child have a dentist?	○ Yes	○ No	○ Unsure
	Does your child's primary water source contain fluoride?	○ Yes	○ No	○ 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)?	○ No	○ Yes	○ Unsure
	Has your child had close contact with a person who has tuberculosis disease or who has had a positive tuberculosis test result?	○ No	○ Yes	○ Unsure
	Is your child infected with HIV?	○ No	○ Yes	○ Unsure
Vision	Do you have concerns about how your child sees?	○ No	○ Yes	○ Unsure
	Do your child's eyes appear unusual or seem to cross?	○ No	○ Yes	○ Unsure
	Do your child's eyelids droop or does one eyelid tend to close?	○ No	○ Yes	○ Unsure
	Have your child's eyes ever been injured?	○ No	○ Yes	○ Unsure

ANTICIPATORY GUIDANCE

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

YOUR FAMILY'S HEALTH AND WELL-BEING

Intimate Partner Violence		
Do you always feel safe in your home?	○ Yes	○ No
Has your partner, or another significant person in your life, ever hit, kicked, or shoved you, or physically hurt you or your child?	○ No	○ Yes
Living Situation and Food Security		
Is permanent housing a worry for you?	○ No	○ Yes
Do you have the things you need to take care of your child?	○ Yes	○ No
Does your home have enough heat, hot water, electricity, and working appliances?	○ Yes	○ No
Within the past 12 months, were you ever worried whether your food would run out before you got money to buy more?	○ No	○ Yes
Within the past 12 months, did the food you bought not last, and you did not have money to get more?	○ No	○ Yes
Alcohol and Drugs		
Does anyone in your household drink beer, wine, or liquor?	○ No	○ Yes
Do you or other family members use marijuana, cocaine, pain pills, narcotics, or other controlled substances?	○ No	○ Yes
Taking Care of Yourself		
Do you take time for yourself?	○ Yes	○ No
Do you and your partner spend time alone together?	○ Yes	○ No
Do you and your family do activities together?	○ Yes	○ No
Do you have someone you can turn to if you need to talk about problems?	○ Yes	○ No

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YOUR CHILD'S BEHAVIOR

Is your child learning new things?	○ Yes	○ No
Do you spend time alone with your child doing something that he likes to do?	○ Yes	○ No
Do you encourage other family members and caregivers to be consistent, patient, and calm with your child?	○ Yes	○ No
Do you show your child how to be physically active every day by playing and being active with her?	○ Yes	○ No
Does your child play with other children?	○ Yes	○ No
How much time every day does your child spend watching TV or using computers, tablets, or smartphones?	_____ hours	

TALKING AND YOUR CHILD

Does your child have ways to tell you what he wants?	○ Yes	○ No
Do you use simple words when asking your child a question or telling her what to do?	○ Yes	○ No
Do you give your child plenty of time to respond?	○ Yes	○ No
Do you sing songs and talk with your child about the things you do together?	○ Yes	○ No
Do you read to your child or look at books together every day?	○ Yes	○ No

TOILET TRAINING

Is your child interested in using the toilet?	○ Yes	○ No
Does your child tell you when he has a bowel movement?	○ Yes	○ No
Is your child dry for about 2 hours at a time?	○ Yes	○ No
Does your child know the difference between being wet and dry?	○ Yes	○ No
Do you help your child wash her hands after going to the bathroom?	○ Yes	○ No

SAFETY

Car Safety		
Is your child fastened securely in a rear-facing car safety seat in the back seat every time he rides in a vehicle?	○ Yes	○ No
Does everyone in the vehicle always use a lap and shoulder seat belt, booster seat, or car safety seat?	○ Yes	○ No
Outdoor Safety		
Does your child always wear a bike helmet when she rides on a tricycle, in a towed bike trailer, or in a seat on an adult's bicycle?	○ Yes	○ No
Do you keep your child away from moving machines, lawn mowers, driveways, and streets?	○ Yes	○ No
Do you live near any backyard swimming pools, hot tubs, or spas?	○ No	○ Yes
Gun Safety		
Does anyone in your home or the homes where your child spends time have a gun?	○ No	○ Yes
If yes, is the gun unloaded and locked up?	○ Yes	○ No
If yes, is the ammunition stored and locked up separately from the gun?	○ Yes	○ 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.

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DEDICATED TO THE HEALTH OF ALL CHILDREN®