

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

Please print.

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:

### 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.**

- |  |   |   |
|--|---|---|
| <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

<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
	Do you ever struggle to put food on the table?	<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 (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
<b>Lead</b>	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
<b>Oral health</b>	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
<b>Tuberculosis</b>	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

<b>Living Situation and Food Security</b>		
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
<b>Alcohol and Drugs</b>		
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
<b>Intimate Partner Violence</b>		
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
<b>Safety in the Community</b>		
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

<b>Language Understanding and Fluency</b>		
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



Please print.

## 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>.

