

PATIENT NAME: _____ DATE: _____

Please print.

DATE OF BIRTH: _____

American Academy of Pediatrics



BRIGHT FUTURES PREVISIT QUESTIONNAIRE

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

Please print.

12 MONTH VISIT

DATE OF BIRTH: _____

RISK ASSESSMENT

Hearing	Do you have concerns about how your child hears?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Do you have concerns about how your child speaks?	<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 that was renovated in the past 6 months?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
Oral health	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
Vision	Do you have concerns about how your child sees?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Do your child's eyes appear unusual or seem to cross?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Do your child's eyelids droop or does one eyelid tend to close?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Have your child's eyes ever been injured?	<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			
Do you have enough heat, hot water, electricity, and working appliances in your home?	<input type="radio"/> Yes	<input type="radio"/> No	
Do you have problems with bugs, rodents, peeling paint or plaster, mold, or dampness?	<input type="radio"/> No	<input type="radio"/> Yes	
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	
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?	<input type="radio"/> Yes	<input type="radio"/> No	
Have you talked about your thoughts on feeding, sleeping, discipline, and media use with your caregiver?	<input type="radio"/> Yes	<input type="radio"/> No	
Do you participate in activities outside your home? These may be social, religious, volunteer, or recreational programs.	<input type="radio"/> Yes	<input type="radio"/> No	

CARING FOR YOUR CHILD

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

Please print.

12 MONTH VISIT

DATE OF BIRTH: _____

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	<input type="radio"/> No	<input type="radio"/> Yes
Have you made a family media use plan to help you balance media use with other family activities?	<input type="radio"/> Yes	<input type="radio"/> No

FEEDING YOUR CHILD

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

HEALTHY TEETH

Do you brush your child's teeth with a smear of fluoridated toothpaste 2 times a day using a soft toothbrush?	<input type="radio"/> Yes	<input type="radio"/> 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?	<input type="radio"/> Yes	<input type="radio"/> No
Are you having any problems using your car safety seat?	<input type="radio"/> No	<input type="radio"/> Yes
Do you have a gate at the top and bottom of all stairs in your home?	<input type="radio"/> Yes	<input type="radio"/> No
Is the mattress in your child's crib set on the lowest setting to prevent falls?	<input type="radio"/> Yes	<input type="radio"/> No
Do you keep household cleaners, chemicals, and medicines locked up and out of your child's sight and reach?	<input type="radio"/> Yes	<input type="radio"/> No
Do all your electrical outlets have covers?	<input type="radio"/> Yes	<input type="radio"/> No
Do you keep sharp objects, plastic bags, and electrical or drapery cords out of your child's reach?	<input type="radio"/> Yes	<input type="radio"/> No
Do you keep your child away from the stove, fireplaces, and space heaters?	<input type="radio"/> Yes	<input type="radio"/> No
Are your TVs, bookcases, and dressers secured to the wall so they cannot fall over and hurt your child?	<input type="radio"/> Yes	<input type="radio"/> No
Water and Sun Safety		
Do you always stay within arm's reach of your child when he is in the bath?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have a swimming pool, pond, or lake in or near your home?	<input type="radio"/> No	<input type="radio"/> Yes
Do you put a hat on your child and apply sunscreen on her when you go outside?	<input type="radio"/> Yes	<input type="radio"/> No
Pets		
Do you own a pet?	<input type="radio"/> No	<input type="radio"/> Yes
If so, does your child interact with the pet?	<input type="radio"/> NA	<input type="radio"/> No <input type="radio"/> 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>.

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.

The American Academy of Pediatrics (AAP) does not review or endorse any modifications made to this questionnaire and in no event shall the AAP be liable for any such changes.

© 2019 American Academy of Pediatrics. All rights reserved.