

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

Please print.

DATE OF BIRTH: \_\_\_\_\_

American Academy of Pediatrics



# BRIGHT FUTURES PREVISIT QUESTIONNAIRE

## 15 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"/> Imitate scribbling.  | <input type="checkbox"/> Use 3 words other than names.                       | <input type="checkbox"/> Crawl up a few steps.                                       |
| <input type="checkbox"/> Drink from cup with little spilling.   | <input type="checkbox"/> Speak in sounds that seem like an unknown language. | <input type="checkbox"/> Run.  |
| <input type="checkbox"/> Point to ask for something or to get help.   | <input type="checkbox"/> Follow directions that do not include a gesture.    | <input type="checkbox"/> Make marks with a crayon.                                   |
| <input type="checkbox"/> Look around when you say things such as "Where's your ball?" and "Where's your blanket?" | <input type="checkbox"/> Squat to pick up objects.                           | <input type="checkbox"/> Drop an object into and take the object out of a container. |

Please print.

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**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>Hearing</b> | 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 |
| <b>Vision</b>  | 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?**

**TALKING AND FEELING**

|   |                           |                           |
|---|---------------------------|---------------------------|
| Is your child learning new things?  | <input type="radio"/> Yes | <input type="radio"/> No  |
| Does your child show any worries or fears when meeting new people?                            | <input type="radio"/> No  | <input type="radio"/> Yes |
| Do you take time for yourself?  | <input type="radio"/> Yes | <input type="radio"/> No  |
| Do you spend time alone with your partner?  | <input type="radio"/> Yes | <input type="radio"/> No  |
| Does your child point to something he wants and then watch to see if you see what he’s doing? | <input type="radio"/> Yes | <input type="radio"/> No  |
| Does she wave “bye-bye”?  | <input type="radio"/> Yes | <input type="radio"/> No  |
| Do you talk to, sing to, and look at books with your child every day?                         | <input type="radio"/> Yes | <input type="radio"/> No  |

**SLEEP ROUTINES AND ISSUES**

|   |                           |                           |
|---|---------------------------|---------------------------|
| Does your child have a regular bedtime routine?                                     | <input type="radio"/> Yes | <input type="radio"/> No  |
| Does your child sleep well?   | <input type="radio"/> Yes | <input type="radio"/> No  |
| How many hours does your child sleep?<br>____ Daytime ____ Nighttime                |                           |                           |
| Does your child have a blanket, stuffed animal, or toy that he likes to sleep with? | <input type="radio"/> Yes | <input type="radio"/> No  |
| Do you have a TV or an Internet-connected device in your child’s bedroom?           | <input type="radio"/> No  | <input type="radio"/> Yes |

**TANTRUMS AND DISCIPLINE**

|   |                           |                           |
|---|---------------------------|---------------------------|
| Does your child have frequent tantrums?   | <input type="radio"/> No  | <input type="radio"/> Yes |
| If your child is upset, do you help distract her with another activity, book, or toy?           | <input type="radio"/> Yes | <input type="radio"/> No  |
| Do you set limits for your child?   | <input type="radio"/> Yes | <input type="radio"/> No  |
| Do other caregivers set the same limits for your child as you do?                               | <input type="radio"/> Yes | <input type="radio"/> No  |
| Do you praise your child when he is being good?   | <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 |

**HEALTHY TEETH**

|   |                           |                           |
|---|---------------------------|---------------------------|
| Has your child been to a dentist?   | <input type="radio"/> Yes | <input type="radio"/> No  |
| 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  |
| Does your child use a bottle?   | <input type="radio"/> No  | <input type="radio"/> Yes |

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Please print.

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### SAFETY

| Car and Home Safety   |                           |                          |
|---|---------------------------|--------------------------|
| Is your child fastened securely in a rear-facing car safety seat in the back seat every time she rides in a vehicle?  | <input type="radio"/> Yes | <input type="radio"/> No |
| Does everyone 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 |
| Do you keep cleaners and medicines locked up and out of your child's sight and reach?   | <input type="radio"/> Yes | <input type="radio"/> No |
| Do you have emergency phone numbers near every telephone and in your cell phone for rapid dial?   | <input type="radio"/> Yes | <input type="radio"/> No |
| Do you keep furniture away from windows and use operable window guards on windows on the second floor and higher? (Operable means that, in case of an emergency, an adult can open the window.) | <input type="radio"/> Yes | <input type="radio"/> No |
| Do you have a gate at the top and bottom of all stairs in your home?  | <input type="radio"/> Yes | <input type="radio"/> No |
| Do you keep cigarettes, lighters, matches, and alcohol out of your child's sight and reach?   | <input type="radio"/> Yes | <input type="radio"/> No |
| Do you keep your child away from the stove?   | <input type="radio"/> Yes | <input type="radio"/> No |
| Do you have working smoke alarms on every floor of your home?   | <input type="radio"/> Yes | <input type="radio"/> No |
| Do you test the batteries once a month?   | <input type="radio"/> Yes | <input type="radio"/> No |
| Do you have a fire escape plan?   | <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>.

American Academy of Pediatrics

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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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