Bright Futures Previsit Questionnaire

4 Year Visit

For us to provide you and your child with the best possible health care, we would like to know how things are going.

Please answer all of 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?

We are interested in answering your questions. Please check off the boxes for the topics you would like to discuss the most today.

**Getting Ready for School**
- How your child is doing in preschool
- How your child plays with other children
- If your child is ready for grade school
- How your child is speaking
- Your child's feelings
- Your child's weight

**Healthy Habits**
- How your child is eating
- Brushing teeth
- How your child is sleeping

**TV and Media**
- How much TV is too much TV
- Encouraging your child to be active

**Your Community**
- Fun activities to do outside the home
- Educational programs in the community
- Getting along with other children and adults
- Feeling safe in your home
- Playing safely with other children
- Answering questions about your child's body

**Safety**
- Car safety seats and booster seats
- Being safe outside
- Gun safety
- Keeping your child safe from sexual abuse

**Questions About Your Child**

Have any of your child's relatives developed new medical problems since your last visit? If yes, please describe:
- Yes
- No
- Unsure

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**Lead**
- Does your child have a sibling or playmate who has or had lead poisoning?
- Does your child live in a house or child care facility built before 1978 that is being or has recently been (within the past 6 months) renovated or remodeled?
- Does your child live in a house or child care facility built before 1950?

**Tuberculosis**
- Was your child born in a country at high risk for tuberculosis (countries other than the United States, Canada, Australia, New Zealand, or Western Europe)?
- Has your child traveled (had contact with resident population) for longer than 1 week to a country at high risk for tuberculosis?
- Has a family member or contact had tuberculosis or a positive tuberculin skin test?
- Is your child infected with HIV?

**Dyslipidemia**
- Does your child have parents or grandparents who have had a stroke or heart problem before age 55?
- Does your child have a parent with elevated blood cholesterol (240 mg/dl. or higher) or who is taking cholesterol medication?

**Anemia**
- Do you ever struggle to put food on the table?
- Does your child's diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?

Have there been any major changes in your family lately? 
- Move
- Job change
- Separation
- Divorce
- Death in the family
- Any other changes?

Does your child live with anyone who uses tobacco or spend time in any place where people smoke? 
- No
- Yes

**Your Growing and Developing Child**

Do you have specific concerns about your child's development, learning, or behavior? 
- No
- Yes, describe:

Does your child have any special health care needs? 
- No
- Yes, describe:

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Check off each of the tasks that your child is able to do.

- Builds a tower of 8 small blocks
- Copies a cross
- Can balance on each foot
- Names 4 colors
- Hops on 1 foot
- Draws a person with 3 parts
- Dresses herself, including buttons
- Plays pretend by himself and with others
- Knows her name, age, and whether she is a boy or girl
- Plays board or card games
- Other people can understand what he is saying
- Brushes own teeth