

PATIENT NAME: _____ DATE: _____

Please print.

American Academy of Pediatrics



BRIGHT FUTURES PREVISIT QUESTIONNAIRE

3 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 urinate by herself. | <input type="checkbox"/> Speak so strangers can understand 75% of what he says. | <input type="checkbox"/> Pedal a tricycle. |
| <input type="checkbox"/> Put on a coat, jacket, or shirt by himself. | <input type="checkbox"/> Tell you a story from a book or TV. | <input type="checkbox"/> Climb on and off a couch or chair. |
| <input type="checkbox"/> Eat by herself. | <input type="checkbox"/> Compare things using words such as <i>bigger</i> and <i>shorter</i> . | <input type="checkbox"/> Jump forward. |
| <input type="checkbox"/> Begin to play make-believe. | <input type="checkbox"/> Understand simple prepositions, such as <i>on</i> or <i>under</i> . | <input type="checkbox"/> Draw a single circle. |
| <input type="checkbox"/> Play and share with others. | | <input type="checkbox"/> Draw a person with head and one other body part. |
| <input type="checkbox"/> Use 3-word sentences. | | <input type="checkbox"/> Cut with child scissors. |

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3 YEAR VISIT

RISK ASSESSMENT

Anemia	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
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 was renovated in the past 6 months?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
Oral health	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
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

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?	<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
Positive Family Interactions		
Are your family members loving and affectionate with one another?	<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 ways to constructively handle anger and settle disputes in your family?	<input type="radio"/> Yes	<input type="radio"/> No
Does everyone who cares for your child set the same limits for your child?	<input type="radio"/> Yes	<input type="radio"/> No
Do you allow your child to make choices, such as what clothes to wear or what books to read?	<input type="radio"/> Yes	<input type="radio"/> No
Do you use simple words when asking your child a question or telling her what to do?	<input type="radio"/> Yes	<input type="radio"/> No
Taking Care of Yourself		
Do you take time for yourself?	<input type="radio"/> Yes	<input type="radio"/> No
Do you feel you are able to balance family and work?	<input type="radio"/> Yes	<input type="radio"/> No
Do you spend time alone with your partner?	<input type="radio"/> Yes	<input type="radio"/> No

PLAYING WITH SIBLINGS AND PEERS

Does your child engage in fantasy play with dolls, toy animals, or blocks?	<input type="radio"/> Yes	<input type="radio"/> No
Do you spend time alone with your child doing things you both enjoy?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child have chances to play with other children (such as on playdates and at preschool)?	<input type="radio"/> Yes	<input type="radio"/> No

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3 YEAR VISIT

PLAYING WITH SIBLINGS AND PEERS (CONTINUED)

When your child plays with other children, do you help him learn how to take turns?	<input type="radio"/> Yes	<input type="radio"/> No
If you have other children, do they get along with each other?	<input type="radio"/> NA	<input type="radio"/> Yes <input type="radio"/> No
Are you expecting or thinking about having another child?	<input type="radio"/> No	<input type="radio"/> Yes

READING AND TALKING WITH YOUR CHILD

Do you read, sing songs, or play word games with your child every day?	<input type="radio"/> Yes	<input type="radio"/> No
When you are reading together, do you ask your child questions about the pictures or story in the book?	<input type="radio"/> Yes	<input type="radio"/> No
Do you encourage your child to tell you about his day?	<input type="radio"/> Yes	<input type="radio"/> No
Does your family speak more than one language at home?	<input type="radio"/> No	<input type="radio"/> Yes

EATING HEALTHY AND BEING ACTIVE

Nutritious Foods		
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
Promoting Physical Activity and Limiting TV		
Are you physically active together as a family, such as going on walks or playing in the park?	<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
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

SAFETY

Car and Home Safety		
Is your child buckled securely in a 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 with your car seat?	<input type="radio"/> No	<input type="radio"/> Yes
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 cut foods such as grapes and hot dogs into small pieces to prevent choking?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child play in a driveway or close to the street?	<input type="radio"/> No	<input type="radio"/> Yes
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
Water Safety		
Are there swimming pools near your home?	<input type="radio"/> No	<input type="radio"/> Yes
Do you always stay within arm's reach of your child when he is in or near water?	<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
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

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3 YEAR VISIT

SAFETY (CONTINUED)

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>.

