

American Academy of Pediatrics



# BRIGHT FUTURES PREVISIT QUESTIONNAIRE

## 5 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"/> Is beginning to skip.              | <input type="checkbox"/> Spread with a knife.  | <input type="checkbox"/> Answer "why" questions.                         |
| <input type="checkbox"/> Walk on tiptoes when asked.        | <input type="checkbox"/> Dress and undress without help.   | <input type="checkbox"/> Count 5 objects.                                |
| <input type="checkbox"/> Catch a bounced ball with 2 hands. | <input type="checkbox"/> Urinate and have a bowel movement on her own.   | <input type="checkbox"/> Name 3 or more single numbers.                  |
| <input type="checkbox"/> Copy a triangle.                   | <input type="checkbox"/> Is dry through the day.   | <input type="checkbox"/> Name 4 or more letters out of alphabetic order. |
| <input type="checkbox"/> Draw a 6-part person.              | <input type="checkbox"/> Tell a story of 2 sentences or more.  | <input type="checkbox"/> Write 2 or more letters.                        |
| <input type="checkbox"/> Copy first name.                   | <input type="checkbox"/> Follow directions for 4 individual prepositions, such as <i>on, under, behind, and in front of.</i> |  |
| <input type="checkbox"/> Cut well with scissors.            | <input type="checkbox"/> Play and interact with peers.   |  |

## 5 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>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>Neighborhood and Family Violence (Bullying and Fighting)</b>		
Are there frequent reports of violence in your community or school?	<input type="radio"/> No	<input type="radio"/> Yes
Has your child ever been bullied or hurt physically by someone?	<input type="radio"/> No	<input type="radio"/> Yes
Has your child ever bullied or been aggressive with others?	<input type="radio"/> No	<input type="radio"/> Yes
<b>Food Security</b>		
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>		
Is there anyone in your child's life whose alcohol or drug use concerns you?	<input type="radio"/> No	<input type="radio"/> Yes
<b>Emotional Security and Self-Esteem</b>		
Does your child usually seem happy?	<input type="radio"/> Yes	<input type="radio"/> No
Are there things your child is really good at doing or is proud of?	<input type="radio"/> Yes	<input type="radio"/> No
<b>Connectedness With Family</b>		
Does your family get along well with each other?	<input type="radio"/> Yes	<input type="radio"/> No
Does your family do things together?	<input type="radio"/> Yes	<input type="radio"/> No

#### FAMILY RULES AND ROUTINES

Does your child have chores or responsibilities at home?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have clear rules and expectations for your child?	<input type="radio"/> Yes	<input type="radio"/> No
When your child breaks the rules, are you consistent with consequences and discipline?	<input type="radio"/> Yes	<input type="radio"/> No
Do you let your child know when she is being good?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child have problems dealing with angry feelings?	<input type="radio"/> No	<input type="radio"/> Yes
Do you help your child control his anger?	<input type="radio"/> Yes	<input type="radio"/> No

#### SCHOOL

Did your child attend a preschool program?	<input type="radio"/> Yes	<input type="radio"/> No
Has your child started elementary school?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have any concerns about your child's school experience?	<input type="radio"/> NA	<input type="radio"/> No <input type="radio"/> Yes

Please print.

## 5 YEAR VISIT

### SCHOOL (CONTINUED)

Are you able to attend activities or functions at your child's school?	<input type="radio"/> NA	<input type="radio"/> Yes	<input type="radio"/> No
Is your child involved in after-school activities?	<input type="radio"/> NA	<input type="radio"/> Yes	<input type="radio"/> No
Does your child receive any special education services?		<input type="radio"/> No	<input type="radio"/> Yes

### STAYING HEALTHY

<b>Healthy Teeth</b>			
Does your child brush his teeth twice a day?	<input type="radio"/> Yes	<input type="radio"/> No	
Does your child see the dentist twice a year?	<input type="radio"/> Yes	<input type="radio"/> No	
<b>Nutrition</b>			
Do you have any concerns about your child's eating? This includes drinking enough milk and eating vegetables and fruits.	<input type="radio"/> No	<input type="radio"/> Yes	
Does your child drink soda, juice, or other sugar-sweetened drinks?	<input type="radio"/> No	<input type="radio"/> Yes	
Does your child eat breakfast every day?	<input type="radio"/> Yes	<input type="radio"/> No	
<b>Physical Activity</b>			
Is your child physically active at least 1 hour every day? This includes running, playing sports, or active play with friends.	<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 (not counting schoolwork)?	_____ hours		
Does your child have a TV or an Internet-connected device in his bedroom?	<input type="radio"/> No	<input type="radio"/> Yes	
Has your family made a family 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 have trouble going to sleep or does he wake up during the night?	<input type="radio"/> No	<input type="radio"/> Yes	
Does your child have a regular bedtime?	<input type="radio"/> Yes	<input type="radio"/> No	

### SAFETY

<b>Car Safety</b>			
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	
<b>Outdoor Safety</b>			
Does your child always wear a helmet to protect her head when biking, skating, or doing other outdoor activities?	<input type="radio"/> Yes	<input type="radio"/> No	
Does your child know street safety habits, such as stopping at the curb, looking both ways, and never crossing the street without a grown-up?	<input type="radio"/> Yes	<input type="radio"/> No	
Does your child know how to swim?	<input type="radio"/> Yes	<input type="radio"/> No	
Does your child know to always have an adult watching her in the water and never to swim alone?	<input type="radio"/> Yes	<input type="radio"/> No	
Does your child always use sunscreen when playing outside?	<input type="radio"/> Yes	<input type="radio"/> No	
<b>Home Fire Safety</b>			
Do you have working smoke alarms installed on every level of your home?	<input type="radio"/> Yes	<input type="radio"/> No	
Do you have carbon monoxide detectors/alarms in your home?	<input type="radio"/> Yes	<input type="radio"/> No	
Do you have an emergency escape plan in case of fire?	<input type="radio"/> Yes	<input type="radio"/> No	
Does your child know what to do if the fire alarm rings?	<input type="radio"/> Yes	<input type="radio"/> No	

Please print.

## 5 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
Have you talked with your child about gun safety?	<input type="radio"/> Yes	<input type="radio"/> No
Harm From Adults		
Have you taught your child that it is never OK for an adult to tell a child to keep secrets from her parents?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child know that it is never OK for an older child or an adult to ask to see his private parts?	<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>.

