CLEAR FORM

PATIENT NAME: _____ DATE: _____

Please print.

American Academy of Pediatrics

# BRIGHT FUTURES PREVISIT QUESTIONNAIRE
# 11 THROUGH 14 YEAR VISITS FOR PARENTS

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 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

**Check off all the items that you feel are true for your child.**

- ☐ My child does things that help her have a healthy lifestyle, such as eating healthy foods, being physically active, and keeping herself safe.
- ☐ My child has at least one adult in his life who cares about him and knows he can go to if he needs help.
- ☐ My child has at least one friend or a group of friends who she feels comfortable around.
- ☐ My child helps others by himself or by working with a group in school, a faith-based organization, or the community.
- ☐ My child is able to bounce back when things don't go her way.
- ☐ My child feels hopeful and self-confident.
- ☐ My child is becoming more independent and making more decisions on his own as he gets older.

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# 11 THROUGH 14 YEAR VISITS FOR PARENTS

## RISK ASSESSMENT

| | | | | |
|---|---|---|---|---|
| **Anemia** | Does your child's diet include iron-rich foods, such as meat, iron-fortified cereals, or beans? | O Yes | O No | O Unsure |
| | Has your child ever been diagnosed with iron deficiency anemia? | O No | O Yes | O Unsure |
| | Does your family ever struggle to put food on the table? | O No | O Yes | O Unsure |
| | **If your child is female,** does she have excessive menstrual bleeding or other blood loss? | O No | O Yes | O Unsure |
| | **If your child is female,** does her period last more than 5 days? | O No | O Yes | O Unsure |
| **Dyslipidemia** | Does your child have parents, grandparents, or aunts or uncles who have had a stroke or heart problem before age 55 (males) or 65 (females)? | O No | O Yes | O Unsure |
| | Does your child have a parent with an elevated blood cholesterol level (240 mg/dL or higher) or who is taking cholesterol medication? | O No | O Yes | O Unsure |
| **Hearing** | Do you have concerns about how your child hears? | O No | O Yes | O Unsure |
| **Oral health** | Does your child's primary water source contain fluoride? | O Yes | O No | O Unsure |
| **Sexually transmitted infections/ HIV** | Adolescents who are sexually active are at risk of sexually transmitted infection, including HIV. Adolescents who use injection drugs are at risk of HIV. Are you concerned that your young adolescent might be at risk? | O No | O Yes | O Unsure |
| **Tuberculosis** | Is your child infected with HIV? | O No | O Yes | O Unsure |
| | 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)? | O No | O Yes | O Unsure |
| | Has your child had close contact with a person who has tuberculosis disease or who has had a positive tuberculosis test result? | O No | O Yes | O Unsure |
| **Vision** | Do you have concerns about how your child sees? | O No | O Yes | O Unsure |
| | Does your child have trouble with near or far vision? | O No | O Yes | O Unsure |
| | Has your child ever failed a school vision screening test? | O No | O Yes | O Unsure |
| | Does your child tend to squint? | O No | O Yes | O Unsure |

## ANTICIPATORY GUIDANCE

### How are things going for you, your child, and your family?

### YOUR FAMILY'S HEALTH AND WELL-BEING

| **Interpersonal Violence (Fighting and Bullying)** | | | |
|---|---|---|---|
| Are there frequent reports of violence in your community or school? | O No | O Sometimes | O Yes |
| Is your child involved in any of the violence? | O No | O Sometimes | O Yes |
| Do you think your child is safe in the neighborhood? | O Yes | O Sometimes | O No |
| Has your child ever been injured in a fight? | O No | O Sometimes | O Yes |
| Has your child been bullied or hurt by others? | O No | O Sometimes | O Yes |
| Has your child bullied or been aggressive toward others? | O No | O Sometimes | O Yes |
| Have you talked with your child about violence in dating situations and how to be safe? | O Yes | O Sometimes | O No |
| **Living Situation and Food Security** | | | |
| Do you have concerns about your living situation? | O No | O Sometimes | O Yes |
| Do you have enough heat, hot water, and electricity? | O Yes | O Sometimes | O No |
| Do you have appliances that work? | O Yes | O Sometimes | O No |
| Do you have problems with bugs, rodents, or peeling paint or plaster? | O No | O Sometimes | O Yes |
| In the past 12 months, did you worry that your food would run out before you got money to buy more? | O No | O Sometimes | O Yes |
| In the past 12 months, did the food you bought not last, and you did not have money to buy more? | O No | O Sometimes | O Yes |

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## YOUR FAMILY'S HEALTH AND WELL-BEING (*CONTINUED*)

| | | | |
|---|---|---|---|
| **Alcohol and Drugs** | | | |
| Is there anyone in your child's life whose alcohol or drug use concerns you? | O No | O Sometimes | O Yes |
| **Connectedness With Family and Peers** | | | |
| Does your family get along well with each other? | O Yes | O Sometimes | O No |
| Do you take time to talk with your child every day? | O Yes | O Sometimes | O No |
| Does your family do things together? | O Yes | O Sometimes | O No |
| Does your child have chores or responsibilities at home? | O Yes | O Sometimes | O No |
| Do you have clear rules and expectations for your child? | O Yes | O Sometimes | O No |
| Do you let your child know when he does something good? | O Yes | O Sometimes | O No |
| **Connectedness With Community** | | | |
| Does your child have interests outside of school? | O Yes | O Sometimes | O No |
| Does your child help others at home, in school, or in your community? | O Yes | O Sometimes | O No |
| **School Performance** | | | |
| Is your child getting to school on time? | O Yes | O Sometimes | O No |
| Is your child having any problems at school? | O No | O Sometimes | O Yes |
| Does your child complete homework on time? | O Yes | O Sometimes | O No |
| Has your child missed more than 2 days of school in any month? | O No | O Sometimes | O Yes |
| **Coping With Stress and Decision-making** | | | |
| Does your child worry too much or appear overly anxious? | O No | O Sometimes | O Yes |
| Have you discussed ways to deal with stress? | O Yes | O Sometimes | O No |
| Do you help your child make decisions and solve problems? | O Yes | O Sometimes | O No |

## YOUR GROWING AND CHANGING CHILD

| | | | |
|---|---|---|---|
| **Healthy Teeth** | | | |
| Does your child see the dentist regularly? | O Yes | O Sometimes | O No |
| Do you have trouble getting dental care? | O No | O Sometimes | O Yes |
| **Body Image** | | | |
| Do you have any concerns about your child's nutrition, weight, or physical activity? | O No | O Sometimes | O Yes |
| Does your child talk about getting fat or dieting to lose weight? | O No | O Sometimes | O Yes |
| **Healthy Eating** | | | |
| Do you think your child eats healthy foods? | O Yes | O Sometimes | O No |
| Do you have any difficulty getting healthy food for your family? | O No | O Sometimes | O Yes |
| Do you have any concerns about your child's eating habits or nutrition? | O No | O Sometimes | O Yes |
| Do you eat meals together as a family? | O Yes | O Sometimes | O No |
| **Physical Activity and Sleep** | | | |
| Is your child physically active at least 1 hour a day? This includes running, playing sports, or doing physically active things with friends. | O Yes | O Sometimes | O No |
| Are there opportunities to safely play outside in your neighborhood? | O Yes | O Sometimes | O No |
| Do you and your child participate in physical activities together? | O Yes | O Sometimes | O No |
| How much time does your child spend on recreational screen time each day? | _____ hours | | |
| Does your child have a TV, computer, tablet, or smartphone in his bedroom? | O No | O Sometimes | O Yes |
| Do you have rules about screen time for your child? | O Yes | O Sometimes | O No |
| Has your family made a family media use plan to help everyone balance time spent on media with other family and personal activities? | O Yes | O Sometimes | O No |
| Does your child have a regular bedtime? | O Yes | O Sometimes | O No |

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## YOUR CHILD'S EMOTIONAL WELL-BEING

| | | | |
|---|---|---|---|
| **Mood and Mental Health** | | | |
| Is your child frequently irritable? | O No | O Sometimes | O Yes |
| Have you noticed any changes in your child's weight or sleep habits? | O No | O Sometimes | O Yes |
| Do you and your child often have conflicts about what your culture expects for her behavior and how her friends behave? | O No | O Sometimes | O Yes |
| Do you have any concerns about your child's emotional health, such as being frequently sad or depressed? | O No | O Sometimes | O Yes |
| **Sexuality** | | | |
| Have you and your child talked about how his body will change during puberty? | O Yes | O Sometimes | O No |
| Do you have house rules about curfews, dating, and friends? | O Yes | O Sometimes | O No |

## HEALTHY BEHAVIOR CHOICES

| | | | |
|---|---|---|---|
| **Sexual Activity** | | | |
| Have you and your child talked about sex? | O Yes | O Sometimes | O No |
| Have you talked about ways to deal with any pressures to have sex? | O Yes | O Sometimes | O No |
| **Substance Use** | | | |
| Have you talked with your child about alcohol and drug use? | O Yes | O Sometimes | O No |
| Do you know your child's friends? | O Yes | O Sometimes | O No |
| Do you know where your child is and what she does after school and on the weekends? | O Yes | O Sometimes | O No |
| Do you have consequences for your child if you discover he is using tobacco, alcohol, or drugs? | O Yes | O Sometimes | O No |
| To your knowledge, is your child currently using alcohol or drugs, or has she used them in the past? | O No | O Sometimes | O Yes |
| **Acoustic Trauma** | | | |
| Does your child often listen to loud music? | O No | O Sometimes | O Yes |

## SAFETY

| | | | |
|---|---|---|---|
| **Seat Belt and Helmet Use** | | | |
| Do you always wear a lap and shoulder seat belt and bicycle helmet? | O Yes | O Sometimes | O No |
| Do you insist your child wears a lap and shoulder seat belt when in a car? | O Yes | O Sometimes | O No |
| Do you insist that your child use a life jacket when he does water sports? | O Yes | O Sometimes | O No |
| **Sun Protection** | | | |
| Does your child use sunscreen? | O Yes | O Sometimes | O No |
| **Gun Safety** | | | |
| Is there a gun in your home or the homes where your child visits? | O No | O Sometimes | O Yes |
| If yes, is the gun unloaded and locked up? | O Yes | O Sometimes | O No |
| If yes, is the ammunition stored and locked up separately from the gun? | O Yes | O Sometimes | O No |
| Have you talked with your child about gun safety? | O Yes | O Sometimes | O 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.

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