CLEAR FORM

PATIENT NAME: _____ DATE: _____

Please print.

American Academy of Pediatrics

# BRIGHT FUTURES PREVISIT QUESTIONNAIRE

# 4 YEAR VISIT

Bright Futures™

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.**

- ☐ Go to the bathroom and have a bowel movement by himself.
- ☐ Dress and undress without much help.
- ☐ Play make-believe.
- ☐ Answer questions such as "What do you do when you are cold?" and "When you are sleepy?"
- ☐ Use 4-word sentences.
- ☐ Speak so strangers can understand 100% of what she says.
- ☐ Draw pictures you recognize.
- ☐ Follow simple rules when playing board or card games.
- ☐ Tell you a story from a book.
- ☐ Skip on one foot.
- ☐ Climb stairs, using one foot, then the other, without support.
- ☐ Draw a person with at least 3 body parts.
- ☐ Draw a simple cross.
- ☐ Unbutton and button medium-sized buttons.
- ☐ Grasp a pencil with a thumb and fingers instead of her fist.

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# 4 YEAR VISIT

## 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 |
| | Do you ever struggle to put food on the table? | 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 (male) or 65 (female)? | O No | O Yes | O Unsure |
| | Does your child have a parent with elevated blood cholesterol level (240 mg/dL or higher) or who is taking cholesterol medication? | O No | O Yes | O 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? | O No | O Yes | O Unsure |
| **Oral health** | Does your child have a dentist? | O Yes | O No | O Unsure |
| | Does your child's primary water source contain fluoride? | O Yes | O No | O 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)? | 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 |
| | Is your child infected with HIV? | 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

| | | |
|---|---|---|
| **Living Situation and Food Security** | | |
| Is permanent housing a worry for you? | O No | O Yes |
| Do you have enough heat, hot water, electricity, and working appliances? | O Yes | O No |
| Within the past 12 months, were you ever worried whether your food would run out before you got money to buy more? | O No | O Yes |
| Within the past 12 months, did the food you bought not last, and you did not have money to get more? | O No | O Yes |
| **Alcohol and Drugs** | | |
| Does anyone in your household drink beer, wine, or liquor? | O No | O Yes |
| Do you or other family members use marijuana, cocaine, pain pills, narcotics, or other controlled substances? | O No | O Yes |
| **Intimate Partner Violence** | | |
| Do you always feel safe in your home? | O Yes | O No |
| Has your partner, or another significant person in your life, ever hit, kicked, or shoved you, or physically hurt you or your child? | O No | O Yes |
| **Safety in the Community** | | |
| Do you feel safe in your community? | O Yes | O No |
| Do you have someone you can turn to if you are concerned about your child's safety? | O Yes | O No |
| Do you have connections to your community through faith groups, volunteer organizations, or recreational programs? | O Yes | O No |
| Do you spend time with parents of other children in your community? | O Yes | O No |

### GETTING READY FOR SCHOOL

| | | |
|---|---|---|
| **Language Understanding and Fluency** | | |
| Does your child clearly communicate his wants and needs to you and others? | O Yes | O No |
| Do you respond to your child's questions with short and simple answers? | O Yes | O No |
| Do you give your child plenty of time to tell a story or answer a question? | O Yes | O No |
| Do you talk, sing, and read together every day? | O Yes | O No |

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# 4 YEAR VISIT

## GETTING READY FOR SCHOOL (*CONTINUED*)

| | | |
|---|---|---|
| **Feelings** | | |
| Is your child generally happy and active? | O Yes | O No |
| Do you help your child say, "I'm sorry," for hurting others' feelings? | O Yes | O No |
| **Opportunities to Socialize With Other Children** | | |
| Is your child interested in other children? | O Yes | O No |
| Does your child have a chance to play with other children in playgroups or at preschool? | O Yes | O No |
| Does your child have a best friend? | O Yes | O No |
| Do you praise your child when she is good or has finished a task? | O Yes | O No |
| **Early Childhood Programs and Preschool** | | |
| Does your child attend preschool? | O Yes | O No |
| Are you happy with your child care or preschool arrangement? | O Yes | O No |
| Do you visit your child's preschool and participate in activities there? | O Yes | O No |
| **Readiness for School** | | |
| Do you have any concerns about your child starting school in the coming year? | O No | O Yes |
| Are you doing things to get your child ready for preschool? This could include reading together and going to the library, the park, the zoo, and other places. | O Yes | O No |

## HEALTHY HABITS

| | | |
|---|---|---|
| **Nutrition** | | |
| Does your child drink water every day? | O Yes | O 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? | O Yes | O No |
| Is your child willing to try new flavors and food textures? | O Yes | O No |
| Do you let your child decide how much to eat and when to stop? | O Yes | O No |
| **Daily Routines That Promote Health** | | |
| Does your child sleep well? | O Yes | O No |
| Do you have a regular bedtime and mealtime routines? | O Yes | O No |
| Do you brush your child's teeth twice a day with a pea-sized amount of fluoridated toothpaste? | O Yes | O No |

## LIMITING TV AND PROMOTING PHYSICAL ACTIVITY

| | | |
|---|---|---|
| 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? | O No | O Yes |
| Has your family made a media use plan to help everyone balance time spent on media with other family and personal activities? | O Yes | O No |
| Does your child play actively for at least 1 hour a day? | O Yes | O No |
| Does your child play with other children? | O Yes | O No |
| Are you physically active together as a family, such as going for walks or playing in the park? | O Yes | O No |

## SAFETY

| | | |
|---|---|---|
| **Car Safety** | | |
| 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? | O Yes | O No |
| Does everyone else in the vehicle always use a lap and shoulder seat belt, booster seat, or car safety seat? | O Yes | O No |

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# 4 YEAR VISIT

## SAFETY (*CONTINUED*)

| | | |
|---|---|---|
| **Outdoor Safety** | | |
| Do you watch your child closely when she plays outside, especially near streets and driveways? | O Yes | O No |
| Are there swimming pools in your neighborhood? | O No | O Yes |
| Are you planning to have your child learn to swim? | O Yes | O No |
| Does your child always wear an US Coast Guard–approved life jacket when on a boat? | O Yes | O No |
| Does your child always use sunscreen when he plays outside? | O Yes | O No |
| **Pets** | | |
| Do you own a pet? | O No | O Yes |
| Have you taught your child how to behave around animals so she does not get bitten or scratched? | O Yes | O No |
| **Gun Safety** | | |
| Does anyone in your home or the homes where your child spends time have a gun? | O No | O Yes |
| If yes, is the gun unloaded and locked up? | O Yes | O No |
| If yes, is the ammunition stored and locked up separately from the gun? | O Yes | 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.

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®