



BRIGHT FUTURES PREVISIT QUESTIONNAIRE

2 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. **Autism Spectrum Disorder screening is also part of this visit.** 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"/> Play with other children and express interest in their play. | <input type="checkbox"/> Follow a 2-step command (such as "Pick it up and put it away"). | <input type="checkbox"/> Run with coordination. |
| <input type="checkbox"/> Take off some clothing. | <input type="checkbox"/> Name at least 5 body parts. | <input type="checkbox"/> Climb up a ladder at a playground. |
| <input type="checkbox"/> Scoop well with a spoon. | <input type="checkbox"/> Speak so strangers can understand 50% of what he says. | <input type="checkbox"/> Stack objects. |
| <input type="checkbox"/> Use 50 words. | <input type="checkbox"/> Kick a ball. | <input type="checkbox"/> Turn book pages. |
| <input type="checkbox"/> Combine 2 words into a short phrase or sentence. | <input type="checkbox"/> Jump off the ground with 2 feet. | <input type="checkbox"/> Use his hands to turn objects. |
| | | <input type="checkbox"/> Draw lines. |

2 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
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)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Does your child have a parent with elevated blood cholesterol level (240 mg/dL or higher) or who is taking cholesterol medication?	<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
Vision	Do you have concerns about how your child sees?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Do your child's eyes appear unusual or seem to cross?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Do your child's eyelids droop or does one eyelid tend to close?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Have your child's eyes ever been injured?	<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

Intimate Partner Violence		
Do you always feel safe in your home?	<input type="radio"/> Yes	<input type="radio"/> No
Has your partner, or another significant person in your life, ever hit, kicked, or shoved you, or physically hurt you or your child?	<input type="radio"/> No	<input type="radio"/> Yes
Living Situation and Food Security		
Is permanent housing a worry for you?	<input type="radio"/> No	<input type="radio"/> Yes
Do you have the things you need to take care of your child?	<input type="radio"/> Yes	<input type="radio"/> No
Does your home have enough heat, hot water, electricity, and working appliances?	<input type="radio"/> Yes	<input type="radio"/> No
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
Taking Care of Yourself		
Do you take time for yourself?	<input type="radio"/> Yes	<input type="radio"/> No
Do you and your partner spend time alone together?	<input type="radio"/> Yes	<input type="radio"/> No
Do you and your family do activities together?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have someone you can turn to if you need to talk about problems?	<input type="radio"/> Yes	<input type="radio"/> No

Please print.

2 YEAR VISIT

YOUR CHILD'S BEHAVIOR

Is your child learning new things?	<input type="radio"/> Yes	<input type="radio"/> No
Do you spend time alone with your child doing something that he likes to do?	<input type="radio"/> Yes	<input type="radio"/> No
Do you encourage other family members and caregivers to be consistent, patient, and calm with your child?	<input type="radio"/> Yes	<input type="radio"/> No
Do you show your child how to be physically active every day by playing and being active with her?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child play with other children?	<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	

TALKING AND YOUR CHILD

Does your child have ways to tell you what he wants?	<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
Do you give your child plenty of time to respond?	<input type="radio"/> Yes	<input type="radio"/> No
Do you sing songs and talk with your child about the things you do together?	<input type="radio"/> Yes	<input type="radio"/> No
Do you read to your child or look at books together every day?	<input type="radio"/> Yes	<input type="radio"/> No

TOILET TRAINING

Is your child interested in using the toilet?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child tell you when he has a bowel movement?	<input type="radio"/> Yes	<input type="radio"/> No
Is your child dry for about 2 hours at a time?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child know the difference between being wet and dry?	<input type="radio"/> Yes	<input type="radio"/> No
Do you help your child wash her hands after going to the bathroom?	<input type="radio"/> Yes	<input type="radio"/> No

SAFETY

Car Safety		
Is your child fastened securely in a rear-facing car safety seat in the back seat every time he rides in a vehicle?	<input type="radio"/> Yes	<input type="radio"/> No
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
Outdoor Safety		
Does your child always wear a bike helmet when she rides on a tricycle, in a towed bike trailer, or in a seat on an adult's bicycle?	<input type="radio"/> Yes	<input type="radio"/> No
Do you keep your child away from moving machines, lawn mowers, driveways, and streets?	<input type="radio"/> Yes	<input type="radio"/> No
Do you live near any backyard swimming pools, hot tubs, or spas?	<input type="radio"/> No	<input type="radio"/> Yes
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>.

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®



The information contained in this questionnaire should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances. Original questionnaire included as part of the *Bright Futures Tool and Resource Kit, 2nd Edition*.

The American Academy of Pediatrics (AAP) does not review or endorse any modifications made to this questionnaire and in no event shall the AAP be liable for any such changes.

© 2019 American Academy of Pediatrics. All rights reserved.