



Bright Futures Previsit Questionnaire

12 Month Visit

For us to provide you and your child with the best possible health care, we would like to know how things are going. Please answer all of 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?

We are interested in answering your questions. Please check off the boxes for the topics you would like to discuss the most today.

Family Support	<input type="checkbox"/> Ways to manage your child's behavior	<input type="checkbox"/> Finding time for yourself	<input type="checkbox"/> Parent/family community activities			
Establishing Routines	<input type="checkbox"/> Nap time routines	<input type="checkbox"/> Bedtime routines	<input type="checkbox"/> Brushing teeth	<input type="checkbox"/> Starting family traditions		
Feeding Your Child	<input type="checkbox"/> Using a spoon and cup	<input type="checkbox"/> Healthy food choices	<input type="checkbox"/> How many meals or snacks a day	<input type="checkbox"/> How much your child should eat	<input type="checkbox"/> Change in appetite and growth	<input type="checkbox"/> Your child's weight
Finding a Dentist	<input type="checkbox"/> Your child's first dental checkup	<input type="checkbox"/> Brushing teeth twice daily	<input type="checkbox"/> Finger sucking, pacifiers, and bottles			
Safety	<input type="checkbox"/> Home safety indoors and outdoors	<input type="checkbox"/> Car safety seats	<input type="checkbox"/> Water safety	<input type="checkbox"/> Gun safety	<input type="checkbox"/> Older siblings watching your child	<input type="checkbox"/> Foods that might cause choking

Questions About Your Child

Have any of your child's relatives developed new medical problems since your last visit? If yes, please describe: Yes No Unsure

Hearing	Do you have concerns about how your child hears?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Do you have concerns about how your child speaks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Vision	Do you have concerns about how your child sees?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Does your child hold objects close when trying to focus?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Do your child's eyes appear unusual or seem to cross, drift, or be lazy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Do your child's eyelids droop or does one eyelid tend to close?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Have your child's eyes ever been injured?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Lead	Does your child have a sibling or playmate who has or had lead poisoning?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Does your child live in or regularly visit a house or child care facility built before 1978 that is being or has recently been (within the past 6 months) renovated or remodeled?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Does your child live in or regularly visit a house or child care facility built before 1950?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Tuberculosis	Was your child born in a country at high risk for tuberculosis (countries other than the United States, Canada, Australia, New Zealand, or Western Europe)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Has your child traveled (had contact with resident populations) for longer than 1 week to a country at high risk for tuberculosis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Has a family member or contact had tuberculosis or a positive tuberculin skin test?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Is your child infected with HIV?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Oral Health	Do you know a dentist to whom you can bring your child?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unsure
	Does your child's primary water source contain fluoride?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unsure

Does your child have any special health care needs? No Yes, describe:

Have there been any major changes in your family lately? Move Job change Separation Divorce Death in the family Any other problems?

Does your child live with anyone who uses tobacco or spend time in any place where people smoke? No Yes



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.

- Bangs toys together
- Waves bye-bye
- Tries to do what you do
- Stands alone
- Drinks from a cup
- Speaks 1 to 2 words
- Babbles
- Tries to make the same sounds you do
- Looks at things you are looking at
- Cries when you leave
- Hands you a book to read
- Follows simple directions
- Plays peekaboo



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