



# Bright Futures Previsit Questionnaire 4 Year 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.

<b>Getting Ready for School</b>	<input type="checkbox"/> How your child is doing in preschool	<input type="checkbox"/> How your child does playing with other children
	<input type="checkbox"/> If your child is ready for grade school	<input type="checkbox"/> How your child is speaking
	<input type="checkbox"/> Your child's feelings	<input type="checkbox"/> Your child's weight
<b>Healthy Habits</b>	<input type="checkbox"/> How your child is eating	<input type="checkbox"/> Brushing teeth
	<input type="checkbox"/> How your child is sleeping	
<b>TV and Media</b>	<input type="checkbox"/> How much TV is too much TV	<input type="checkbox"/> Encouraging your child to be active
<b>Your Community</b>	<input type="checkbox"/> Fun activities to do outside the home	<input type="checkbox"/> Educational programs in the community
	<input type="checkbox"/> Getting along with other children and adults	<input type="checkbox"/> Feeling safe in your home
	<input type="checkbox"/> Answering questions about your child's body	<input type="checkbox"/> Playing safely with other children
<b>Safety</b>	<input type="checkbox"/> Car safety seats and booster seats	<input type="checkbox"/> Being safe outside
	<input type="checkbox"/> Gun safety	<input type="checkbox"/> Keeping your child safe from sexual abuse

## 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

<b>Lead</b>	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
<b>Tuberculosis</b>	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
<b>Dyslipidemia</b>	Is your child infected with HIV?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Does your child have parents or grandparents who have had a stroke or heart problem before age 55?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Does your child have a parent with elevated blood cholesterol (240 mg/dL or higher) or who is taking cholesterol medication?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
<b>Anemia</b>	Do you ever struggle to put food on the table?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Does your child's diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unsure

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

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:

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

Check off each of the tasks that your child is able to do.

- Builds a tower of 8 small blocks
- Copies a cross
- Can balance on each foot
- Names 4 colors
- Hops on 1 foot
- Draws a person with 3 parts
- Dresses herself, including buttons
- Plays pretend by himself and with others
- Knows her name, age, and whether she is a boy or girl
- Plays board or card games
- Other people can understand what he is saying
- Brushes own teeth



### American Academy of Pediatrics



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