

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

Please print.

American Academy of Pediatrics



# BRIGHT FUTURES PREVISIT QUESTIONNAIRE

## 10 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. 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 items that are true for your child.

- Shows the ability to get along with others and control his emotions
- Chooses to eat healthy foods and participate in physical activity every day
- Forms caring, supportive relationships with family members, other adults, and peers

Please print.

## 10 YEAR VISIT

### RISK ASSESSMENT

<b>Anemia</b>	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
	Does your child eat a vegetarian diet (does not eat red meat, chicken, fish, or seafood)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	If your child is a vegetarian (does not eat red meat, chicken, fish, or seafood), does your child take an iron supplement?	<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
<b>Oral health</b>	Does your child's primary water source contain fluoride?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unsure
<b>Tuberculosis</b>	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

### ANTICIPATORY GUIDANCE

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

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

<b>Neighborhood and Family Violence</b>		
Are there frequent reports of violence in your community or school?	<input type="radio"/> No	<input type="radio"/> Yes
Has your child ever been bullied or hurt physically by someone?	<input type="radio"/> No	<input type="radio"/> Yes
Has your child felt excluded or not a part of any group of friends?	<input type="radio"/> No	<input type="radio"/> Yes
Has your child ever told you she was touched in a way that made her uncomfortable or on her private parts?	<input type="radio"/> No	<input type="radio"/> Yes
<b>Food Security</b>		
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
<b>Tobacco, E-cigarettes, Alcohol, and Drugs</b>		
Is there anyone in your child's life whose alcohol or drug use concerns you?	<input type="radio"/> No	<input type="radio"/> Yes
Do any of your child's friends smoke, use or vape e-cigarettes, drink alcohol or beer, or use drugs?	<input type="radio"/> No	<input type="radio"/> Yes
<b>Harm From the Internet</b>		
Do you know about your child's Internet use?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have rules for the Internet?	<input type="radio"/> Yes	<input type="radio"/> No
Have you installed an Internet safety filter on computers, tablets, and smartphones?	<input type="radio"/> Yes	<input type="radio"/> No
<b>Emotional Security and Self-esteem</b>		
Does your child usually seem happy?	<input type="radio"/> Yes	<input type="radio"/> No
Are there things your child is really good at doing or is proud of?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child have the chance to help others at home, at school, or in your community?	<input type="radio"/> Yes	<input type="radio"/> No
<b>Connectedness With Family and Peers</b>		
Do your family members get along well with each other?	<input type="radio"/> Yes	<input type="radio"/> No
Does your family do things together?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child have chores or responsibilities at home?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child have friends at school or in your neighborhood?	<input type="radio"/> Yes	<input type="radio"/> No

Please print.

## 10 YEAR VISIT

### YOUR GROWING CHILD

Temper Problems, Setting Reasonable Limits, and Friends		
Has your child experienced any recent stresses at home or in school?	<input type="radio"/> No	<input type="radio"/> Yes
Do you have clear rules and expectations for your child?	<input type="radio"/> Yes	<input type="radio"/> No
When your child breaks the rules, are you consistent with consequences and discipline?	<input type="radio"/> Yes	<input type="radio"/> No
Do you help your child control his anger, deal with worries, and solve problems?	<input type="radio"/> Yes	<input type="radio"/> No
Have you and your child talked about how to say no to smoking, alcohol, and drug use?	<input type="radio"/> Yes	<input type="radio"/> No
Onset of Puberty and Sexual Safety		
Have you talked with your child about the body changes that occur during puberty?	<input type="radio"/> Yes	<input type="radio"/> No
Have you discussed privacy and body safety with your child?	<input type="radio"/> Yes	<input type="radio"/> No
Have you and your child talked about sex?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child know to tell a trusted adult if someone touches her private parts or if someone encourages her to do other things that make her uncomfortable or she knows are wrong?	<input type="radio"/> Yes	<input type="radio"/> No

### SCHOOL

Do you have concerns about your child's school experience?	<input type="radio"/> No	<input type="radio"/> Yes
Has your child missed more than 2 days of school in any month?	<input type="radio"/> No	<input type="radio"/> Yes
Does your child have any difficulties at school or get extra help in any subjects?	<input type="radio"/> No	<input type="radio"/> Yes
Does your child participate in activities outside of school?	<input type="radio"/> Yes	<input type="radio"/> No

### STAYING HEALTHY

Healthy Teeth		
Does your child have a dentist?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child brush and floss his teeth every day?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child use a mouth guard when playing contact sports?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child regularly drink soda, juice, or other sugar-sweetened drinks?	<input type="radio"/> No	<input type="radio"/> Yes
Nutrition		
Do you have any concerns about your child's weight?	<input type="radio"/> No	<input type="radio"/> Yes
Do you have any concerns about her eating? This includes drinking enough milk and eating vegetables and fruits.	<input type="radio"/> No	<input type="radio"/> Yes
Do you eat family meals together?	<input type="radio"/> Yes	<input type="radio"/> No
Do you hear your child talking about how he looks or dieting?	<input type="radio"/> No	<input type="radio"/> Yes
Physical Activity		
Is your child physically active at least 1 hour a day? This includes running, playing sports, or active play with friends.	<input type="radio"/> Yes	<input type="radio"/> No
Do you have any concerns about your child's physical activity level, such as it being either too much or too little?	<input type="radio"/> No	<input type="radio"/> Yes
Does your child have trouble going to sleep or does she wake up during the night?	<input type="radio"/> No	<input type="radio"/> Yes
How much time every day does your child spend watching TV, playing video games, or using computers, tablets, or smartphones (not counting schoolwork)?	_____ hours	
Does your child have a TV or an Internet-connected device in his bedroom?	<input type="radio"/> No	<input type="radio"/> Yes
Has your family made a family media use plan to help everyone balance time spent on media with other family and personal activities?	<input type="radio"/> Yes	<input type="radio"/> No

### SAFETY

Car Safety		
Does your child always sit in a belt-positioning booster seat or lap and shoulder seat belt in the back seat every time she 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?	<input type="radio"/> Yes	<input type="radio"/> No
Safety During Physical Activity		
Does your child always wear a helmet to protect his head when biking, skating, or doing other outdoor activities?	<input type="radio"/> Yes	<input type="radio"/> No

Please print.

## 10 YEAR VISIT

### SAFETY (CONTINUED)

Outdoor Safety		
Does your child know how to swim?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child know to always have an adult watching her in the water and never to swim alone?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child always use sunscreen when playing outside?	<input type="radio"/> Yes	<input type="radio"/> No
Knowing Your Child's Friends and Their Families		
Do you know your child's friends and their families?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child know how to get help in an emergency if you are not there?	<input type="radio"/> Yes	<input type="radio"/> No
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
Have you talked with your child about gun safety?	<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>.



# Questions About Your Child and Tuberculosis (TB)

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Your Name \_\_\_\_\_

Today's Date \_\_\_\_\_

We need your help to find out if your child has been exposed to the disease tuberculosis, also known as TB.

TB is caused by germs. It is usually spread to another person by coughing or sneezing. A person can have TB germs in their body but not have active TB disease. TB can be prevented and treated. Your answers to the questions below will let us know if your child might have been exposed to TB. If your answers show your child might have picked up the TB germs, we will want to give him or her a tuberculin skin test (TST). The skin test is not a vaccination. It will not prevent TB. It will only let us know if your child has the TB germs.

Check the box that matches your answer:	Yes	No	Do Not Know
1. Has your child been tested for TB? If yes, when? Please tell us the date ___/___/___			
2. Have you ever been told that your child had a positive tuberculin skin test (TST)? If yes, when? Please tell us the date ___/___/___			
3. TB can cause fever that can last days or weeks. It can cause weight loss, a bad cough (lasting over two weeks), or coughing up blood. a. Has your child been around anyone with any of these problems? b. Has your child been around anyone sick with TB? c. Has your child ever had any of these problems or do they have them now?			
4. Was your child born in another part of the world like Mexico or Latin America, the Caribbean, Africa, Eastern Europe, or Asia?			
5. Has your child been to Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe, or Asia for more than 3 weeks? Which country or countries did your child visit?			
6. Do you know if your child has spent more than 3 weeks with anyone who: Uses needles for drug use? Has AIDS? Was or is in jail or prison? Has just come to the United States from another country?			

**FOR THE PROVIDER:**

If the prior test was negative and the answer to #4 is yes, the child does not need a repeat skin test.  
If the prior test was negative and occurred at least 8 weeks after the situation described in #3a, 3b, 5, or 6, the child does not need a repeat skin test.  
If the prior test was positive, the child does not need a repeat skin test; but a positive answer to #3c would indicate a chest x-ray as soon as possible.

TST administered Yes \_\_\_ No \_\_\_

If yes, Date administered \_\_\_/\_\_\_/\_\_\_ Date read \_\_\_/\_\_\_/\_\_\_ TST reaction \_\_\_\_\_ mm

TST provider \_\_\_\_\_  
Signature \_\_\_\_\_ Printed Name \_\_\_\_\_

If chest x-ray done, date \_\_\_\_\_ and results \_\_\_\_\_

Provider phone number \_\_\_\_\_ City \_\_\_\_\_ County \_\_\_\_\_

If positive, referral to local/regional health department/specialist? Yes \_\_\_ No \_\_\_

If yes, name of health dept./specialist \_\_\_\_\_

Contact your local or regional health department if assistance is needed.