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#### **American Academy of Pediatrics**

# BRIGHT FUTURES PREVISIT QUESTIONNAIRE 12 MONTH 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 W	OULD YOU LIKE TO TALK ABOUT	TODAY?
Do you have any concerns, questions, or prob	lems that you would like to discuss today? ○ <b>N</b>	o O Yes, describe:
TELI	L US ABOUT YOUR CHILD AND FAI	MILY.
What excites or delights you most about your of	child?	
Does your child have special health care need	s? O <b>No</b> O <b>Yes,</b> describe:	
Have there been major changes lately in your	child's or family's life? O <b>No</b> O <b>Yes</b> , describe:	
Have any of your child's relatives developed ne please describe:	w medical problems since your last visit? O <b>No</b>	O Yes O Unsure If yes or unsure,
Does your child live with anyone who smokes	or spend time in places where people smoke or	use e-cigarettes? O No O Yes O Unsure
YOU	IR GROWING AND DEVELOPING C	HILD
Do you have specific concerns about your child	d's development, learning, or behavior? O <b>No</b>	O <b>Yes,</b> describe:
Check off each of the tasks that your child i	s able to do.	
<ul> <li>□ Look for hidden objects.</li> <li>□ Imitate new gestures.</li> <li>□ Say, "Dad" or "Mom" with meaning</li> <li>□ Use one word other than <i>Mom</i>, <i>Dad</i>, or</li> </ul>	<ul> <li>□ Follow a verbal command that includes a gesture.</li> <li>□ Take first independent steps.</li> <li>□ Stand without support.</li> </ul>	<ul><li>□ Drop objects in a cup.</li><li>□ Pick up small object with 2-finger pincer grasp.</li><li>□ Pick up food and eat it.</li></ul>

PATIENT NAME:		DATE:	
	Please print.		

## **12 MONTH VISIT**

## **RISK ASSESSMENT**

	Do you have concerns about how your child hears?	O No	O Yes	O Unsure
Hearing	Do you have concerns about how your child speaks?	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 that was renovated in the past 6 months?	O No	O Yes	O Unsure
Oral health	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
	Do you have concerns about how your child sees?	O No	O Yes	O Unsure
Vision	Do your child's eyes appear unusual or seem to cross?	O No	O Yes	O Unsure
	Do your child's eyelids droop or does one eyelid tend to close?	O No	O Yes	O Unsure
	Have your child's eyes ever been injured?	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				
Do you have enough heat, hot water, electricity, and working appliances in your home?	O Yes	O No		
Do you have problems with bugs, rodents, peeling paint or plaster, mold, or dampness?	O No	O Yes		
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		
Social Connections With Family, Friends, Child Care, Home Visitation Program Staff, and Others				
Do you have child care or an adult you trust to care for your child?	O Yes	O No		
Have you talked about your thoughts on feeding, sleeping, discipline, and media use with your caregiver?	O Yes	O No		
Do you participate in activities outside your home? These may be social, religious, volunteer, or recreational programs.	O Yes	O No		

#### **CARING FOR YOUR CHILD**

If your child is upset, do you help distract him using another activity, book, or toy?	O Yes	O No
Do you use time-outs as a way to manage your child's behavior?	O Yes	O No
Do you have any questions about what to do when you become angry or frustrated with your child?	O No	O Yes
Does your family regularly make time for reading, playing, and talking together?	O Yes	O No
Do you eat together as a family?	O Yes	O No
Do you have regular mealtimes and snack times?	O Yes	O No
Do you help your child feel comfortable around new people and new situations?	O Yes	O No
Do you have regular nap time and bedtime routines for your child, such as reading books and brushing teeth?	O Yes	O No

PATIENT NAME:	DATE:		
Please print.			
12 MONTH VISIT			
CARING FOR YOUR CHILD (CONTINUED)			
Does your child watch TV or play on a tablet or smartphone?  If yes, how much time each day? hours	С	) No	O Yes
Have you made a family media use plan to help you balance media use with other family activities?	C	) Yes	O No
FEEDING YOUR CHILD			
Does your child try feeding herself using a spoon?	C	) Yes	O No
Does your child drink from a cup?	C	) Yes	O No
Do you give your child small, hard foods such as peanuts and popcorn?	C	) No	O Yes
Do you give your child round foods such as hot dogs, raw carrots, grapes, and grape tomatoes?	C	) No	O Yes
Do you include your child in family meals?	C	) Yes	O No
Have you begun to serve your child cow's milk?	C	) Yes	O No
Does your child eat vegetables and fruits?	C	) Yes	O No
Does your child eat foods rich in protein, such as eggs, lean meat, chicken, or fish?	C	) Yes	O No
Do you let your child decide what and how much to eat?	C	) Yes	O No
HEALTHY TEETH			
Do you brush your child's teeth with a smear of fluoridated toothpaste 2 times a day using a soft toothbrush?	? C	) Yes	O No
SAFETY			,
Car and Home Safety			
Is your child fastened securely in a rear-facing car safety seat in the back seat every time he rides in a vehic	le?	) Yes	O No
Are you having any problems using your car safety seat?	C	) No	O Yes
Do you have a gate at the top and bottom of all stairs in your home?	C	) Yes	O No
Is the mattress in your child's crib set on the lowest setting to prevent falls?	C	) Yes	O No
Do you keep household cleaners, chemicals, and medicines locked up and out of your child's sight and reac	:h? C	) Yes	O No
Do all your electrical outlets have covers?	C	) Yes	O No
Do you keep sharp objects, plastic bags, and electrical or drapery cords out of your child's reach?	C	) Yes	O No
Do you keep your child away from the stove, fireplaces, and space heaters?	C	) Yes	O No

Consistent with Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, 4th Edition

Are your TVs, bookcases, and dressers secured to the wall so they cannot fall over and hurt your child?

For more information, go to https://brightfutures.aap.org.



**Water and Sun Safety** 

Do you own a pet?

If so, does your child interact with the pet?

Pets

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.

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Do you always stay within arm's reach of your child when he is in the bath?

Do you put a hat on your child and apply sunscreen on her when you go outside?

Do you have a swimming pool, pond, or lake in or near your home?

O Yes

O Yes

O No

O Yes

O No

O No

O NA

O No

O No

O Yes

O No

O Yes

O Yes

# **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 expo	sed to the disease tub	erculosis,	also known	
TB is caused by germs. It is usually spread to another pe have TB germs in their body but not have active TB disea answers to the questions below will let us know if your chanswers show your child might have picked up the TB ge tuberculin skin test (TST). The skin test is not a vaccination know if your child has the TB germs.	se. TB can be prevent illd might have been ex rms, we will want to giv	ed and tre cposed to re him or	ated. Your TB. If your her a	
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 tuberc				
(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 had			
cough (lasting over two weeks), or coughing up blood.	-		<u> </u>	1
<ul> <li>a. Has your child been around anyone with any of thes</li> <li>b. Has your child been around anyone sick with TB?</li> </ul>	e problems?			
c. Has your child ever had any of these problems or do				
4. Was your child born in another part of the world like Mexico of Caribbean, Africa, Eastern Europe, or Asia?	r Latin America, the			
<ol><li>Has your child been to Mexico or any other country in Latin A Caribbean, Africa, Eastern Europe, or Asia for more than 3 wee</li></ol>				
Which country or countries did your child visit?	anvone 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?			
<b>,</b>	,		_L	I
FOR THE PROVIDER: If the prior test was negative and the answer to #4 is yes, If the prior test was negative and occurred at least 8 weel 6, the child does not need a repeat skin test. If the prior test was positive, the child does not need a rep would indicate a chest x-ray as soon as possible.	ks after the situation de	escribed in	n #3a, 3b, 5,	or
TST administered YesNo				
If yes, Date administered//Date read/	/TST reaction	1	mm	
TST providerSignature				_
Signature	Printed N	Name		
If chest x-ray done, date a	nd results			_
Provider phone number	CityC	County		_
If positive, referral to local/regional health department/spe	ecialist? Yes	No		
If yes, name of health dept./specialist				_

TEXAS
Health and Human
Services
Jesus Health Street

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