CLEAR FORM

PATIENT NAME: _____ **DATE:** _____

Please print.

American Academy of Pediatrics

BRIGHT FUTURES PREVISIT QUESTIONNAIRE
5 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 tasks that your child is able to do.

- ☐ Is beginning to skip.
- ☐ Walk on tiptoes when asked.
- ☐ Catch a bounced ball with 2 hands.
- ☐ Copy a triangle.
- ☐ Draw a 6-part person.
- ☐ Copy first name.
- ☐ Cut well with scissors.
- ☐ Spread with a knife.
- ☐ Dress and undress without help.
- ☐ Urinate and have a bowel movement on her own.
- ☐ Is dry through the day.
- ☐ Tell a story of 2 sentences or more.
- ☐ Follow directions for 4 individual prepositions, such as *on, under, behind,* and *in front of.*
- ☐ Play and interact with peers.
- ☐ Answer "why" questions.
- ☐ Count 5 objects.
- ☐ Name 3 or more single numbers.
- ☐ Name 4 or more letters out of alphabetic order.
- ☐ Write 2 or more letters.

PATIENT NAME: _____ **DATE:** _____

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5 YEAR VISIT

RISK ASSESSMENT

Anemia	Does your child's diet include iron-rich foods, such as meat, iron-fortified cereals, or beans?	O Yes	O No	O Unsure
	Do you ever struggle to put food on the table?	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 was renovated in the past 6 months?	O No	O Yes	O Unsure
Oral health	Does your child have a dentist?	O Yes	O No	O Unsure
	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

ANTICIPATORY GUIDANCE

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

YOUR FAMILY'S HEALTH AND WELL-BEING

Neighborhood and Family Violence (Bullying and Fighting)		
Are there frequent reports of violence in your community or school?	O No	O Yes
Has your child ever been bullied or hurt physically by someone?	O No	O Yes
Has your child ever bullied or been aggressive with others?	O No	O Yes
Food Security		
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		
Is there anyone in your child's life whose alcohol or drug use concerns you?	O No	O Yes
Emotional Security and Self-Esteem		
Does your child usually seem happy?	O Yes	O No
Are there things your child is really good at doing or is proud of?	O Yes	O No
Connectedness With Family		
Does your family get along well with each other?	O Yes	O No
Does your family do things together?	O Yes	O No

FAMILY RULES AND ROUTINES

Does your child have chores or responsibilities at home?	O Yes	O No
Do you have clear rules and expectations for your child?	O Yes	O No
When your child breaks the rules, are you consistent with consequences and discipline?	O Yes	O No
Do you let your child know when she is being good?	O Yes	O No
Does your child have problems dealing with angry feelings?	O No	O Yes
Do you help your child control his anger?	O Yes	O No

SCHOOL

Did your child attend a preschool program?		O Yes	O No
Has your child started elementary school?		O Yes	O No
Do you have any concerns about your child's school experience?	O NA	O No	O Yes

PATIENT NAME: _____ **DATE:** _____

Please print.

5 YEAR VISIT

SCHOOL (*CONTINUED*)

Are you able to attend activities or functions at your child's school?	O NA	O Yes	O No
Is your child involved in after-school activities?	O NA	O Yes	O No
Does your child receive any special education services?		O No	O Yes

STAYING HEALTHY

Healthy Teeth		
Does your child brush his teeth twice a day?	O Yes	O No
Does your child see the dentist twice a year?	O Yes	O No
Nutrition		
Do you have any concerns about your child's eating? This includes drinking enough milk and eating vegetables and fruits.	O No	O Yes
Does your child drink soda, juice, or other sugar-sweetened drinks?	O No	O Yes
Does your child eat breakfast every day?	O Yes	O No
Physical Activity		
Is your child physically active at least 1 hour every day? This includes running, playing sports, or active play with friends.	O Yes	O No
How much time every day does your child spend watching TV or using computers, tablets, or smartphones (not counting schoolwork)?	_____ hours	
Does your child have a TV or an Internet-connected device in his bedroom?	O No	O Yes
Has your family made a family media use plan to help everyone balance time spent on media with other family and personal activities?	O Yes	O No
Does your child have trouble going to sleep or does he wake up during the night?	O No	O Yes
Does your child have a regular bedtime?	O Yes	O No

SAFETY

Car Safety		
Is your child fastened securely in a car safety seat or belt-positioning booster seat in the back seat every time he rides in a vehicle?	O Yes	O No
Does everyone else in the vehicle always use a lap and shoulder seat belt, booster seat, or car safety seat?	O Yes	O No
Outdoor Safety		
Does your child always wear a helmet to protect her head when biking, skating, or doing other outdoor activities?	O Yes	O No
Does your child know street safety habits, such as stopping at the curb, looking both ways, and never crossing the street without a grown-up?	O Yes	O No
Does your child know how to swim?	O Yes	O No
Does your child know to always have an adult watching her in the water and never to swim alone?	O Yes	O No
Does your child always use sunscreen when playing outside?	O Yes	O No
Home Fire Safety		
Do you have working smoke alarms installed on every level of your home?	O Yes	O No
Do you have carbon monoxide detectors/alarms in your home?	O Yes	O No
Do you have an emergency escape plan in case of fire?	O Yes	O No
Does your child know what to do if the fire alarm rings?	O Yes	O No

PATIENT NAME: _____ **DATE:** _____

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5 YEAR VISIT

SAFETY (*CONTINUED*)

Gun Safety		
Does anyone in your home or the homes where your child spends time have a gun?	O No	O Yes
If yes, is the gun unloaded and locked up?	O Yes	O No
If yes, is the ammunition stored and locked up separately from the gun?	O Yes	O No
Have you talked with your child about gun safety?	O Yes	O No
Harm From Adults		
Have you taught your child that it is never OK for an adult to tell a child to keep secrets from her parents?	O Yes	O No
Does your child know that it is never OK for an older child or an adult to ask to see his private parts?	O Yes	O 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®

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.