

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

Please print.

DATE: \_\_\_\_\_

American Academy of Pediatrics



# BRIGHT FUTURES PREVISIT QUESTIONNAIRE

## 7 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.

## 7 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>Hearing</b>	Do you have concerns about how your child hears?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Do you have concerns about how your child speaks?	<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
<b>Vision</b>	Do you have concerns about how your child sees?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Has your child ever failed a school vision screening test?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Does your child tend to squint?	<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 (Bullying and Fighting)</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 ever bullied or been aggressive with others?	<input type="radio"/> No	<input type="radio"/> Yes
Have you talked with your child about how to get help and who to call if there is an emergency?	<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>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
<b>Harm From the Internet</b>		
Do you supervise your child's Internet use?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have rules about Internet use?	<input type="radio"/> Yes	<input type="radio"/> No
Do you use safety filters 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
<b>Connectedness With Family</b>		
Does your family 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

Please print.

## 7 YEAR VISIT

### YOUR CHILD'S DEVELOPMENT

Does your child have chores or responsibilities at home?	<input type="radio"/> Yes	<input type="radio"/> No
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 let your child know when he is doing a good job?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child frequently have worries?	<input type="radio"/> No	<input type="radio"/> Yes
Does your child have problems dealing with anger or frustration?	<input type="radio"/> No	<input type="radio"/> Yes
Do you help your child control her anger, deal with worries, and solve problems?	<input type="radio"/> Yes	<input type="radio"/> No
<b>Puberty and Pubertal Development</b>		
Have you talked with your child about how his body will change during puberty?	<input type="radio"/> Yes	<input type="radio"/> No

### SCHOOL

Is your child doing well in school?	<input type="radio"/> Yes	<input type="radio"/> No
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?	<input type="radio"/> No	<input type="radio"/> Yes
Does your child like school?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child have friends at school?	<input type="radio"/> Yes	<input type="radio"/> No
Is your child involved in after-school activities?	<input type="radio"/> Yes	<input type="radio"/> No

### STAYING HEALTHY

<b>Healthy Teeth</b>		
Does your child brush her teeth twice a day?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child see the dentist twice a year?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child use a mouth guard if playing contact sports?	<input type="radio"/> Yes	<input type="radio"/> No
<b>Nutrition</b>		
Do you have any concerns about your child's weight or eating habits?	<input type="radio"/> No	<input type="radio"/> Yes
Do you have any concerns about your child's eating? This includes drinking enough milk and eating vegetables and fruits.	<input type="radio"/> No	<input type="radio"/> Yes
Does your child drink or eat 3 servings of dairy foods, such as milk, cheese, or yogurt, a day?	<input type="radio"/> Yes	<input type="radio"/> No
Do you eat meals together as a family?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child drink soda, juice, or other sweetened drinks?	<input type="radio"/> No	<input type="radio"/> Yes
Does your child eat breakfast every day?	<input type="radio"/> Yes	<input type="radio"/> No
<b>Physical Activity</b>		
Is your child physically active at least 1 hour every day? This includes running, playing sports, or active play with friends.	<input type="radio"/> Yes	<input type="radio"/> No
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
Does your child have trouble going to sleep or does he wake up during the night?	<input type="radio"/> No	<input type="radio"/> Yes
Does your child have a regular bedtime?	<input type="radio"/> Yes	<input type="radio"/> No

Please print.

## 7 YEAR VISIT

### 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 wear a lap and shoulder seat belt or belt-positioning booster seat?	<input type="radio"/> Yes	<input type="radio"/> No
Outdoor Safety		
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
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 use sunscreen?	<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
Harm From Adults		
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 aren't there?	<input type="radio"/> Yes	<input type="radio"/> No
Have you taught your child that it is never OK for an adult to tell a child to keep secrets from his parents?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child know that it is never OK for an older child or an adult to ask to see her private parts?	<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>.



