Child Name: _____

Bright Futures Previsit Questionnaire
10 Year Visit

For us to provide 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.

School	☐ How your child is doing in school ☐ Homework ☐ Bullying
Your Growing Child	☐ How your child feels about herself ☐ Dealing with your child's anger ☐ Setting limits for your child ☐ Your child's friends ☐ Readiness for middle school ☐ Your child's sexuality ☐ Puberty
Staying Healthy	☐ Your child's weight ☐ Your child's body image ☐ Eating breakfast ☐ Limiting soft drinks ☐ Eating together as a family ☐ Drinking enough water ☐ Limiting high-fat food ☐ 1 hour of physical activity daily
Healthy Teeth	☐ Regular dentist visits ☐ Brushing teeth twice daily ☐ Flossing daily
Safety	☐ Bicycle and sports safety and helmets ☐ Car safety ☐ Swimming safety ☐ Sunscreen ☐ Knowing your child's friends and their families ☐ Preventing cigarette, alcohol, and drug use ☐ Gun safety

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

_____

Tuberculosis	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)?	☐ Yes	☐ No	☐ Unsure
	Has your child traveled (had contact with resident populations) for longer than 1 week to a country at high risk for tuberculosis?	☐ Yes	☐ No	☐ Unsure
	Has a family member or contact had tuberculosis or a positive tuberculin skin test?	☐ Yes	☐ No	☐ Unsure
	Is your child infected with HIV?	☐ Yes	☐ No	☐ Unsure
Dyslipidemia	Does your child have parents or grandparents who have had a stroke or heart problem before age 55?	☐ Yes	☐ No	☐ Unsure
	Does your child have a parent with elevated blood cholesterol (240 mg/dL or higher) or who is taking cholesterol medication?	☐ Yes	☐ No	☐ Unsure
Anemia	Does your child eat a strict vegetarian diet?	☐ Yes	☐ No	☐ Unsure
	If your child is a vegetarian, does your child take an iron supplement?	☐ No	☐ Yes	☐ Unsure
	Does your child's diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?	☐ No	☐ Yes	☐ Unsure

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

_____

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:

_____

Check off each of the following that are true for your child.

☐ Eats healthy meals and snacks
☐ Has friends
☐ Is doing well in school
☐ Feels good about himself
☐ Gets along with family
☐ Participates in an after-school activity
☐ Vigorously exercises for 1 hour a day
☐ Does chores when asked
☐ Getting chances to make own decisions
☐ Does an activity really well; describe: _____

_____

_____

_____

Bright Futures™ prevention and health promotion for infants, children, adolescents, and their families™

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

*** CONTINUE TO BACK FOR IMPORTANT HEALTH AND SAFETY QUESTIONS ***

Westerville Pediatric Specialists, Inc.

Child Name: _____

The questions below are to be answered by PARENT/LEGAL GUARDIAN.

HEALTH AND SAFETY

We are devoted to the health and safety of you and your family. Please tell us how comfortable you feel with the following necessities:

I have enough **MONEY** to provide for my family.

Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly Agree
☐	☐	☐	☐	☐

I am able to provide **FOOD** for my family.

Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly Agree
☐	☐	☐	☐	☐

I am able to provide **HOUSING** for my family.

Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly Agree
☐	☐	☐	☐	☐

I am able to provide or arrange **TRANSPORTATION** for my family.

Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly Agree
☐	☐	☐	☐	☐

Westerville Pediatric Specialists, Inc.
575 Westar Crossing, Suite 101
Westerville OH 43082
Tel: 614/508-2223
Fax: 614/508-2233

CHOLESTEROL LIPID PANEL SCREENING

The American Academy of Pediatrics recommends that all children receive dyslipidemia screening between ages 9 to 11 and then again for those between 17-21 years old. The procedure consists of a simple finger stick and is analyzed in office.

I, _____ give my consent for my child
Parent's Name (printed)

_____, to have the cholesterol lipid panel screening performed by
Child's Name (printed)

Westerville Pediatric Specialists, Inc.

I **ACCEPT** cholesterol lipid panel screening at this time for my child.

Date _____ Signature _____

I **DECLINE** cholesterol lipid panel screening at this time for my child.

Date _____ Signature _____

Westerville Pediatric Specialists, Inc.
575 Westar Crossing, Suite 101
Westerville OH 43082
Tel: 614/508-2223
Fax: 614/508-2233

VISION and/or HEARING SCREENINGS

The American Academy of Pediatrics recommends vision and hearing screenings be done on various ages of children starting at age 3 years and above. If your child has not been tested by your school system, we can provide those services in our office.

I, _____ give my consent for my child
Parent's Name (printed)

_____, to have a vision and hearing screening performed by
Child's Name (printed)
Westerville Pediatric Specialists, Inc.

I **ACCEPT** the vision and/or hearing screening at this time for my child.

Date _____ Signature _____

I **DECLINE** the vision and/or hearing screening at this time for my child.

Date _____ Signature _____