Child Name: _____

Bright Futures Previsit Questionnaire
2 Year Visit

For us to provide you and 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.

Your Talking Child	☐ How your child talks ☐ Reading together
How Your Child Behaves	☐ Praising your child ☐ Helping your child express feelings ☐ Knowing how to give your child limited choices ☐ Playing with others ☐ Helping your child follow directions ☐ Your child's weight
Toilet Training	☐ Signs your child is ready to potty train ☐ Helping your child potty train
Your Child and TV	☐ How much TV is too much TV ☐ Learning activities other than TV ☐ How to be physically active as a family
Safety	☐ Car safety seats ☐ Bike helmets ☐ Being safe outside ☐ 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

_____

_____

Hearing	Do you have concerns about how your child hears?	☐ Yes	☐ No	☐ Unsure
	Do you have concerns about how your child speaks?	☐ Yes	☐ No	☐ Unsure
Vision	Do you have concerns about how your child sees?	☐ Yes	☐ No	☐ Unsure
	Does your child hold objects close when trying to focus?	☐ Yes	☐ No	☐ Unsure
	Do your child's eyes appear unusual or seem to cross, drift, or be lazy?	☐ Yes	☐ No	☐ Unsure
	Do your child's eyelids droop or does one eyelid tend to close?	☐ Yes	☐ No	☐ Unsure
	Have your child's eyes ever been injured?	☐ Yes	☐ No	☐ Unsure
Lead	Does your child have a sibling or playmate who has or had lead poisoning?	☐ Yes	☐ No	☐ Unsure
	Does your child live in or regularly visit a house or child care facility built before 1978 that is being or has recently been (within the past 6 months) renovated or remodeled?	☐ Yes	☐ No	☐ Unsure
	Does your child live in or regularly visit a house or child care facility built before 1950?	☐ 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	Do you ever struggle to put food on the table?	☐ Yes	☐ No	☐ Unsure
	Does your child's diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?	☐ No	☐ Yes	☐ Unsure
Oral Health	Does your child have a dentist?	☐ No	☐ Yes	☐ Unsure
	Does your child's primary water source contain fluoride?	☐ 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 tasks that your child is able to do.

- ☐ Stacks 5 or 6 small blocks
- ☐ Kicks a ball
- ☐ Walks up and down stairs 1 step at a time alone while holding wall or railing
- ☐ Can point to at least 2 pictures that you name when reading a book
- ☐ Throws a ball overhand
- ☐ Names 1 picture such as a cat, dog, or ball
- ☐ Jumps up
- ☐ Copies things that you do
- ☐ Follows 2-step command
- ☐ When talking, puts 2 words together, like "my book"
- ☐ Turns book pages 1 at a time
- ☐ Plays pretend
- ☐ Plays alongside other children

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
☐	☐	☐	☐	☐

Child Name: _____

Blood Lead Testing Requirements

For Ohio Children less than 6 Years of Age

There is no safe level of lead in the blood.

- All capillary (finger/heel stick) test results ≥ 3.5 µg/dL must be confirmed by venous draw. Point of care instruments such as the LeadCare® II cannot be used to confirm an elevated blood lead level, even if the sample is collected by venipuncture.
- Any confirmed level of lead in the blood is a reliable indicator that the child has been exposed to lead.
- All blood lead test results, by law, are required to be reported to ODH by the analyzing laboratory.
- The Ohio Healthy Homes and Lead Poisoning Prevention Program will respond accordingly to all blood lead levels of 3.5 µg/dL or greater.

If the family answers "Yes" or "Do not know" to ANY of the questions below then TEST—IT'S OHIO LAW! • **TEST at ages 1 and 2 years.** • **TEST between ages 3 and 6 years if the child has no test history.** **If the family answers "No" to all questions, provide prevention guidance and follow up at the next visit.**	**Yes**	**Do Not Know**	**No**
1. Is the child on Medicaid?	☐	☐	☐
2. Home Zip Code: _____	☐	☐	☐
3. Does the child live in or regularly visit a home, child care facility or school built before 1950?	☐	☐	☐
4. Does the child live in or regularly visit a home, child care facility or school built before 1978 that has deteriorated paint?	☐	☐	☐
5. Does the child live in or regularly visit a home built before 1978 with recent ongoing or planned renovation/remodeling?	☐	☐	☐
6. Does the child have a sibling or playmate that has or did have lead poisoning?	☐	☐	☐
7. Does the child frequently come in contact with an adult who has a hobby or works with lead? Examples are construction, welding, pottery, painting and casting ammunition.	☐	☐	☐
8. Does the child live near an active or former lead smelter, battery recycling plant or other industry known to generate airborne lead dust?	☐	☐	☐

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Ohio Department of Health
Ohio Healthy Homes and Lead Poisoning Prevention Program www.odh.ohio.gov

Ohio Department of Health
Ohio Healthy Homes Program