



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.

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

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

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



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