



Child Name: _____

Bright Futures Previsit Questionnaire

15 Month 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.

Talking and Feeling	<input type="checkbox"/> How to handle your upset child when you leave <input type="checkbox"/> Handling your frustrations with your child <input type="checkbox"/> Helping your child speak and learn <input type="checkbox"/> Your child being scared of new people <input type="checkbox"/> Knowing how to give your child limited choices
A Good Night's Sleep	<input type="checkbox"/> Your child's bedtime routine <input type="checkbox"/> Waking up at night
Temper Tantrums and Discipline	<input type="checkbox"/> Temper tantrums <input type="checkbox"/> How to discipline your child <input type="checkbox"/> Encouraging good behavior
Healthy Teeth	<input type="checkbox"/> Stop using the bottle/pacifier <input type="checkbox"/> Brushing teeth <input type="checkbox"/> First dentist visit <input type="checkbox"/> Preventing tooth problems
Safety	<input type="checkbox"/> Car safety seats <input type="checkbox"/> Preventing fires, burns, and poisoning <input type="checkbox"/> How to make your home safe on the inside and outside

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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Do you have concerns about how your child speaks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Vision	Do you have concerns about how your child sees?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Have your child's eyes ever been injured?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Does your child hold objects close when trying to focus?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Do your child's eyes appear unusual or seem to cross, drift, or be lazy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Do your child's eyelids droop or does one eyelid tend to close?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<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 problems?

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.

- | | | |
|---|--|---|
| <input type="checkbox"/> Tries to do what you do | <input type="checkbox"/> Drinks from a cup with very little spilling | <input type="checkbox"/> Helps in the house |
| <input type="checkbox"/> Bends down without falling | <input type="checkbox"/> Says 2 to 3 words | <input type="checkbox"/> Brings toys over to show you |
| <input type="checkbox"/> Walks well | <input type="checkbox"/> Listens to a story | <input type="checkbox"/> Follows simple commands |
| <input type="checkbox"/> Puts block in a cup | | |
| <input type="checkbox"/> Scribbles | | |

List what words your child says.



American Academy of Pediatrics



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