



Child Name: _____

Bright Futures Previsit Questionnaire 18 Month Visit

For us to provide you and your baby 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 Child and Family	<input type="checkbox"/> Taking time for yourself <input type="checkbox"/> Being a role model <input type="checkbox"/> Your child getting along with brothers and sisters <input type="checkbox"/> Family time together <input type="checkbox"/> Having another child <input type="checkbox"/> Getting your child to try new foods <input type="checkbox"/> Your child's weight
Your Child's Behavior	<input type="checkbox"/> How your child acts <input type="checkbox"/> How to tell your child she did a good job <input type="checkbox"/> Fun activities for your child <input type="checkbox"/> Your child being scared in new places <input type="checkbox"/> Setting limits and discipline
Talking and Hearing	<input type="checkbox"/> How your child talks <input type="checkbox"/> Helping your child to learn
Toilet Training	<input type="checkbox"/> Knowing when your child is ready <input type="checkbox"/> How to toilet train
Safety	<input type="checkbox"/> Car safety seats <input type="checkbox"/> Preventing falls, fires, and poisoning <input type="checkbox"/> Gun safety <input type="checkbox"/> Keeping your child safe 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
	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
	Have your child's eyes ever been injured?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Lead	Does your child have a sibling or playmate who has or had lead poisoning?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Does your child live in or regularly visit a house or child care facility built before 1950?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> 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)?	<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
Anemia	Do you ever struggle to put food on the table?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<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
Oral Health	Does your child have a dentist?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unsure
	Does your child's primary water source contain fluoride?	<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 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.

- Knows name of favorite book
- Laughs in response to others
- Runs

- Walks up steps
- Speaks 6 words
- Uses spoon and cup without spilling most of the time

- Points to 1 body part
- Stacks 2 small blocks
- Helps around the house



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