



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

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
Lead	Have your child's eyes ever been injured?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	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
Tuberculosis	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
	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
Dyslipidemia	Is your child infected with HIV?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	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
Anemia	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
	Do you ever struggle to put food on the table?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Oral Health	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 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 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"/> Stacks 5 or 6 small blocks | <input type="checkbox"/> Throws a ball overhand | <input type="checkbox"/> When talking, puts 2 words together, like "my book" |
| <input type="checkbox"/> Kicks a ball | <input type="checkbox"/> Names 1 picture such as a cat, dog, or ball | <input type="checkbox"/> Turns book pages 1 at a time |
| <input type="checkbox"/> Walks up and down stairs 1 step at a time alone while holding wall or railing | <input type="checkbox"/> Jumps up | <input type="checkbox"/> Plays pretend |
| <input type="checkbox"/> Can point to at least 2 pictures that you name when reading a book | <input type="checkbox"/> Copies things that you do | <input type="checkbox"/> Plays alongside other children |
| | <input type="checkbox"/> Follows 2-step command | |



American Academy
of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN™

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate. Original document included as part of *Bright Futures Tool and Resource Kit*. Copyright © 2010 American Academy of Pediatrics. All Rights Reserved. The American Academy of Pediatrics does not review or endorse any modifications made to this document and in no event shall the AAP be liable for any such changes.