Child Name: _____

Bright Futures Previsit Questionnaire
2½ 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.

Family Routines	☐ Setting limits on your child's behavior ☐ All caregivers using the same rules with your child ☐ Your child's weight ☐ Doing fun things as a family ☐ Day and evening routines ☐ Eating together as a family
Learning to Talk and Communicate	☐ How much TV is too much TV ☐ Your child's speech
Getting Along With Others	☐ Playing well with others ☐ How and why to give your child choices
Getting Ready for Preschool	☐ Is your child ready for preschool ☐ Playgroups ☐ Toilet training
Safety	☐ Car safety seats ☐ Staying safe near water ☐ Playing safe outside ☐ Preventing sunburns ☐ Preventing fires ☐ Staying safe with your pets and others

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
Oral Health	Does your child have a dentist?	☐ No	☐ Yes	☐ Unsure
	Does your child's primary water source contain fluoride?	☐ No	☐ Yes	☐ Unsure

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.

- ☐ Points to 6 body parts
- ☐ Jumps up and down in place
- ☐ Puts on clothes with help
- ☐ Other people can understand what your child is saying half the time
- ☐ Washes and dries hands without help
- ☐ Plays pretend
- ☐ Plays with other children, like tag
- ☐ When talking, puts 3 or 4 words together
- ☐ Knows correct animal sounds (such as cat meows, dog barks)
- ☐ Brushes teeth with help

Bright Futures™
prevention and health promotion for infants, children, adolescents, and their families™

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™