

Child Name: \_\_\_\_\_



# Bright Futures Previsit Questionnaire 7 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 learning and doing in school	<input type="checkbox"/> Bullying	<input type="checkbox"/> After-school activities and care
	<input type="checkbox"/> Special education needs	<input type="checkbox"/> How your child acts	<input type="checkbox"/> Talking with your child's school
<b>Your Growing Child</b>	<input type="checkbox"/> How your child feels about herself	<input type="checkbox"/> Following rules	<input type="checkbox"/> Getting ready for puberty
	<input type="checkbox"/> Your child dealing with his problems	<input type="checkbox"/> Becoming more independent	<input type="checkbox"/> Being angry
<b>Staying Healthy</b>	<input type="checkbox"/> Your child's weight	<input type="checkbox"/> 1 hour of physical activity daily	<input type="checkbox"/> Playing sports
	<input type="checkbox"/> Drinking enough water	<input type="checkbox"/> How much your child should eat at one time	<input type="checkbox"/> TV time
<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"/> Booster seats	<input type="checkbox"/> Helmets and sports safety	<input type="checkbox"/> Swimming safety
	<input type="checkbox"/> Knowing your child's computer use	<input type="checkbox"/> Knowing your child's friends and their families	<input type="checkbox"/> Wearing sunscreen
	<input type="checkbox"/> Smoke-free house and cars	<input type="checkbox"/> Preventing sexual abuse	<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>Vision</b>	Do you have concerns about how your child sees?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Has your child ever failed a school vision screening test?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Does your child tend to squint?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
<b>Hearing</b>	Do you have concerns about how your child speaks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Do you have concerns about how your child hears?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Does your child have trouble hearing with a noisy background or over the telephone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
<b>Tuberculosis</b>	Does your child have trouble following the conversation when 2 or more people are talking at the same time?	<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
<b>Anemia</b>	Is your child infected with HIV?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	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"/> Is doing well in school                  | <input type="checkbox"/> Is vigorously active for 1 hour a day |
| <input type="checkbox"/> Has friends                   | <input type="checkbox"/> Participates in an after-school activity | <input type="checkbox"/> Does chores when asked                |
| <input type="checkbox"/> Gets along with family        |   |  |



### American Academy of Pediatrics



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