

Child Name: _____



Bright Futures Previsit Questionnaire 9 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.

School	<input type="checkbox"/> How your child is doing in school	<input type="checkbox"/> Homework	<input type="checkbox"/> Bullying
Your Growing Child	<input type="checkbox"/> How your child feels about herself	<input type="checkbox"/> Dealing with your child's anger	<input type="checkbox"/> Setting limits for your child
	<input type="checkbox"/> Your child's friends	<input type="checkbox"/> Readiness for middle school	<input type="checkbox"/> Your child's sexuality
Staying Healthy	<input type="checkbox"/> Your child's weight	<input type="checkbox"/> Your child's body image	<input type="checkbox"/> Eating breakfast
	<input type="checkbox"/> Eating together as a family	<input type="checkbox"/> Drinking enough water	<input type="checkbox"/> Limiting soft drinks
Healthy Teeth	<input type="checkbox"/> Regular dentist visits	<input type="checkbox"/> Brushing teeth twice daily	<input type="checkbox"/> Flossing daily
Safety	<input type="checkbox"/> Bicycle and sports safety and helmets	<input type="checkbox"/> Car safety	<input type="checkbox"/> Swimming safety
	<input type="checkbox"/> Knowing your child's friends and their families	<input type="checkbox"/> Preventing cigarette, alcohol, and drug use	<input type="checkbox"/> Sunscreen
			<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

Vision	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
Hearing	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
	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
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	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.

- Eats healthy meals and snacks
- Has friends
- Is doing well in school

- Feels good about himself
- Participates in an after-school activity
- Is vigorously active for 1 hour a day
- Gets along with family

- Getting chances to make own decisions
- Does an activity really well; describe: _____



American Academy of Pediatrics



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