



# 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?

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We are interested in answering your questions. Please check off the boxes for the topics you would like to discuss the most today.

|                               |  |
|-------------------------------|--|
| <b>Your Talking Child</b>     | <input type="checkbox"/> How your child talks <input type="checkbox"/> Reading together  |
| <b>How Your Child Behaves</b> | <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<br><input type="checkbox"/> Playing with others <input type="checkbox"/> Helping your child follow directions <input type="checkbox"/> Your child's weight |
| <b>Toilet Training</b>        | <input type="checkbox"/> Signs your child is ready to potty train <input type="checkbox"/> Helping your child potty train  |
| <b>Your Child and TV</b>      | <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  |
| <b>Safety</b>                 | <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

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|---------------------|---|------------------------------|------------------------------|---------------------------------|
| <b>Hearing</b>      | 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 |
| <b>Vision</b>       | 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 |
| <b>Lead</b>         | 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 |
| <b>Tuberculosis</b> | 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 |
| <b>Dyslipidemia</b> | 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 |
| <b>Anemia</b>       | 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 |
| <b>Oral Health</b>  | 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:

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Have there been any major changes in your family lately?  Move     Job change     Separation     Divorce     Death in the family     Any other changes?

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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:

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Check off each of the tasks that your child is able to do.

- Stacks 5 or 6 small blocks
- Kicks a ball
- Walks up and down stairs 1 step at a time alone while holding wall or railing
- Can point to at least 2 pictures that you name when reading a book
- Throws a ball overhand
- Names 1 picture such as a cat, dog, or ball
- Jumps up
- Copies things that you do
- Follows 2-step command
- When talking, puts 2 words together, like “my book”
- Turns book pages 1 at a time
- Plays pretend
- Plays alongside other children



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