CLEAR FORM

PATIENT NAME: _____ **DATE:** _____

Please print.

American Academy of Pediatrics

BRIGHT FUTURES PREVISIT QUESTIONNAIRE
11 THROUGH 14 YEAR VISITS FOR PARENTS

Bright Futures™

To provide you and your child with the best possible health care, we would like to know how things are going. Please answer all 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? ○ **No** ○ **Yes,** describe:

TELL US ABOUT YOUR CHILD AND FAMILY.

What excites or delights you most about your child?

Does your child have special health care needs? ○ **No** ○ **Yes,** describe:

Have there been major changes lately in your family's life? ○ **No** ○ **Yes,** describe:

Have any of your child's relatives developed new medical problems since your last visit? ○ **No** ○ **Yes** ○ **Unsure** If yes or unsure, please describe:

Does your child live with anyone who smokes or spend time in places where people smoke or use e-cigarettes? ○ **No** ○ **Yes** ○ **Unsure**

YOUR GROWING AND DEVELOPING CHILD

Check off all the items that you feel are true for your child.

- ☐ My child does things that help her have a healthy lifestyle, such as eating healthy foods, being physically active, and keeping herself safe.
- ☐ My child has at least one adult in his life who cares about him and knows he can go to if he needs help.
- ☐ My child has at least one friend or a group of friends who she feels comfortable around.
- ☐ My child helps others by himself or by working with a group in school, a faith-based organization, or the community.
- ☐ My child is able to bounce back when things don't go her way.
- ☐ My child feels hopeful and self-confident.
- ☐ My child is becoming more independent and making more decisions on his own as he gets older.

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RISK ASSESSMENT

Anemia	Does your child's diet include iron-rich foods, such as meat, iron-fortified cereals, or beans?	O Yes	O No	O Unsure
	Has your child ever been diagnosed with iron deficiency anemia?	O No	O Yes	O Unsure
	Does your family ever struggle to put food on the table?	O No	O Yes	O Unsure
	If your child is female, does she have excessive menstrual bleeding or other blood loss?	O No	O Yes	O Unsure
	If your child is female, does her period last more than 5 days?	O No	O Yes	O Unsure
Dyslipidemia	Does your child have parents, grandparents, or aunts or uncles who have had a stroke or heart problem before age 55 (males) or 65 (females)?	O No	O Yes	O Unsure
	Does your child have a parent with an elevated blood cholesterol level (240 mg/dL or higher) or who is taking cholesterol medication?	O No	O Yes	O Unsure
Hearing	Do you have concerns about how your child hears?	O No	O Yes	O Unsure
Oral health	Does your child's primary water source contain fluoride?	O Yes	O No	O Unsure
Sexually transmitted infections/ HIV	Adolescents who are sexually active are at risk of sexually transmitted infection, including HIV. Adolescents who use injection drugs are at risk of HIV. Are you concerned that your young adolescent might be at risk?	O No	O Yes	O Unsure
Tuberculosis	Is your child infected with HIV?	O No	O Yes	O Unsure
	Was your child or any household member born in, or has he or she traveled to, a country where tuberculosis is common (this includes countries in Africa, Asia, Latin America, and Eastern Europe)?	O No	O Yes	O Unsure
	Has your child had close contact with a person who has tuberculosis disease or who has had a positive tuberculosis test result?	O No	O Yes	O Unsure
Vision	Do you have concerns about how your child sees?	O No	O Yes	O Unsure
	Does your child have trouble with near or far vision?	O No	O Yes	O Unsure
	Has your child ever failed a school vision screening test?	O No	O Yes	O Unsure
	Does your child tend to squint?	O No	O Yes	O Unsure

ANTICIPATORY GUIDANCE

How are things going for you, your child, and your family?

YOUR FAMILY'S HEALTH AND WELL-BEING

Interpersonal Violence (Fighting and Bullying)			
Are there frequent reports of violence in your community or school?	O No	O Sometimes	O Yes
Is your child involved in any of the violence?	O No	O Sometimes	O Yes
Do you think your child is safe in the neighborhood?	O Yes	O Sometimes	O No
Has your child ever been injured in a fight?	O No	O Sometimes	O Yes
Has your child been bullied or hurt by others?	O No	O Sometimes	O Yes
Has your child bullied or been aggressive toward others?	O No	O Sometimes	O Yes
Have you talked with your child about violence in dating situations and how to be safe?	O Yes	O Sometimes	O No
Living Situation and Food Security			
Do you have concerns about your living situation?	O No	O Sometimes	O Yes
Do you have enough heat, hot water, and electricity?	O Yes	O Sometimes	O No
Do you have appliances that work?	O Yes	O Sometimes	O No
Do you have problems with bugs, rodents, or peeling paint or plaster?	O No	O Sometimes	O Yes
In the past 12 months, did you worry that your food would run out before you got money to buy more?	O No	O Sometimes	O Yes
In the past 12 months, did the food you bought not last, and you did not have money to buy more?	O No	O Sometimes	O Yes

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YOUR FAMILY'S HEALTH AND WELL-BEING (*CONTINUED*)

Alcohol and Drugs			
Is there anyone in your child's life whose alcohol or drug use concerns you?	O No	O Sometimes	O Yes
Connectedness With Family and Peers			
Does your family get along well with each other?	O Yes	O Sometimes	O No
Do you take time to talk with your child every day?	O Yes	O Sometimes	O No
Does your family do things together?	O Yes	O Sometimes	O No
Does your child have chores or responsibilities at home?	O Yes	O Sometimes	O No
Do you have clear rules and expectations for your child?	O Yes	O Sometimes	O No
Do you let your child know when he does something good?	O Yes	O Sometimes	O No
Connectedness With Community			
Does your child have interests outside of school?	O Yes	O Sometimes	O No
Does your child help others at home, in school, or in your community?	O Yes	O Sometimes	O No
School Performance			
Is your child getting to school on time?	O Yes	O Sometimes	O No
Is your child having any problems at school?	O No	O Sometimes	O Yes
Does your child complete homework on time?	O Yes	O Sometimes	O No
Has your child missed more than 2 days of school in any month?	O No	O Sometimes	O Yes
Coping With Stress and Decision-making			
Does your child worry too much or appear overly anxious?	O No	O Sometimes	O Yes
Have you discussed ways to deal with stress?	O Yes	O Sometimes	O No
Do you help your child make decisions and solve problems?	O Yes	O Sometimes	O No

YOUR GROWING AND CHANGING CHILD

Healthy Teeth			
Does your child see the dentist regularly?	O Yes	O Sometimes	O No
Do you have trouble getting dental care?	O No	O Sometimes	O Yes
Body Image			
Do you have any concerns about your child's nutrition, weight, or physical activity?	O No	O Sometimes	O Yes
Does your child talk about getting fat or dieting to lose weight?	O No	O Sometimes	O Yes
Healthy Eating			
Do you think your child eats healthy foods?	O Yes	O Sometimes	O No
Do you have any difficulty getting healthy food for your family?	O No	O Sometimes	O Yes
Do you have any concerns about your child's eating habits or nutrition?	O No	O Sometimes	O Yes
Do you eat meals together as a family?	O Yes	O Sometimes	O No
Physical Activity and Sleep			
Is your child physically active at least 1 hour a day? This includes running, playing sports, or doing physically active things with friends.	O Yes	O Sometimes	O No
Are there opportunities to safely play outside in your neighborhood?	O Yes	O Sometimes	O No
Do you and your child participate in physical activities together?	O Yes	O Sometimes	O No
How much time does your child spend on recreational screen time each day?	_____ hours		
Does your child have a TV, computer, tablet, or smartphone in his bedroom?	O No	O Sometimes	O Yes
Do you have rules about screen time for your child?	O Yes	O Sometimes	O No
Has your family made a family media use plan to help everyone balance time spent on media with other family and personal activities?	O Yes	O Sometimes	O No
Does your child have a regular bedtime?	O Yes	O Sometimes	O No

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YOUR CHILD'S EMOTIONAL WELL-BEING

Mood and Mental Health			
Is your child frequently irritable?	O No	O Sometimes	O Yes
Have you noticed any changes in your child's weight or sleep habits?	O No	O Sometimes	O Yes
Do you and your child often have conflicts about what your culture expects for her behavior and how her friends behave?	O No	O Sometimes	O Yes
Do you have any concerns about your child's emotional health, such as being frequently sad or depressed?	O No	O Sometimes	O Yes
Sexuality			
Have you and your child talked about how his body will change during puberty?	O Yes	O Sometimes	O No
Do you have house rules about curfews, dating, and friends?	O Yes	O Sometimes	O No

HEALTHY BEHAVIOR CHOICES

Sexual Activity			
Have you and your child talked about sex?	O Yes	O Sometimes	O No
Have you talked about ways to deal with any pressures to have sex?	O Yes	O Sometimes	O No
Substance Use			
Have you talked with your child about alcohol and drug use?	O Yes	O Sometimes	O No
Do you know your child's friends?	O Yes	O Sometimes	O No
Do you know where your child is and what she does after school and on the weekends?	O Yes	O Sometimes	O No
Do you have consequences for your child if you discover he is using tobacco, alcohol, or drugs?	O Yes	O Sometimes	O No
To your knowledge, is your child currently using alcohol or drugs, or has she used them in the past?	O No	O Sometimes	O Yes
Acoustic Trauma			
Does your child often listen to loud music?	O No	O Sometimes	O Yes

SAFETY

Seat Belt and Helmet Use			
Do you always wear a lap and shoulder seat belt and bicycle helmet?	O Yes	O Sometimes	O No
Do you insist your child wears a lap and shoulder seat belt when in a car?	O Yes	O Sometimes	O No
Do you insist that your child use a life jacket when he does water sports?	O Yes	O Sometimes	O No
Sun Protection			
Does your child use sunscreen?	O Yes	O Sometimes	O No
Gun Safety			
Is there a gun in your home or the homes where your child visits?	O No	O Sometimes	O Yes
If yes, is the gun unloaded and locked up?	O Yes	O Sometimes	O No
If yes, is the ammunition stored and locked up separately from the gun?	O Yes	O Sometimes	O No
Have you talked with your child about gun safety?	O Yes	O Sometimes	O No

Consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents,* 4th Edition

For more information, go to https://brightfutures.aap.org.

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DEDICATED TO THE HEALTH OF ALL CHILDREN®