PATIENT NAME:		DATE:	
	Please print.		

American Academy of Pediatrics

BRIGHT FUTURES PREVISIT QUESTIONNAIRE 12 MONTH VISIT



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 W	OULD YOU LIKE TO TALK ABOUT	TODAY?
Do you have any concerns, questions, or prob	olems that you would like to discuss today? O N	lo O Yes, describe:
TELI	L US ABOUT YOUR CHILD AND FA	MILY.
What excites or delights you most about your	child?	
Does your child have special health care need	ls? O No O Yes, describe:	
Have there been major changes lately in your	child's or family's life? O No O Yes, describe:	
Have any of your child's relatives developed ne please describe:	w medical problems since your last visit? O No	○ Yes ○ Unsure If yes or unsure,
Does your child live with anyone who smokes	or spend time in places where people smoke or	use e-cigarettes? O No O Yes O Unsure
YOL	JR GROWING AND DEVELOPING C	HILD
Do you have specific concerns about your chil	d's development, learning, or behavior? O No	O Yes , describe:
Check off each of the tasks that your child i	is able to do.	
 □ Look for hidden objects. □ Imitate new gestures. □ Say, "Dad" or "Mom" with meaning □ Use one word other than <i>Mom</i>, <i>Dad</i>, or personal names. 	 ☐ Follow a verbal command that includes a gesture. ☐ Take first independent steps. ☐ Stand without support. 	□ Drop objects in a cup.□ Pick up small object with 2-finger pincer grasp.□ Pick up food and eat it.

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12 MONTH VISIT

RISK ASSESSMENT

Hearing	Do you have concerns about how your child hears?	O No	O Yes	O Unsure
	Do you have concerns about how your child speaks?	O No	O Yes	O Unsure
Lead	Does your child live in or visit a home or child care facility with an identified lead hazard or a home built before 1960 that is in poor repair or that was renovated in the past 6 months?	O No	O Yes	O Unsure
Oral health	Does your child's primary water source contain fluoride?	O Yes	O No	O Unsure
Tuberculosis	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
	Is your child infected with HIV?	O No	O Yes	O Unsure
Vision	Do you have concerns about how your child sees?	O No	O Yes	O Unsure
	Do your child's eyes appear unusual or seem to cross?	O No	O Yes	O Unsure
	Do your child's eyelids droop or does one eyelid tend to close?	O No	O Yes	O Unsure
	Have your child's eyes ever been injured?	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

Living Situation and Food Security			
Do you have enough heat, hot water, electricity, and working appliances in your home?	O Yes	O No	
Do you have problems with bugs, rodents, peeling paint or plaster, mold, or dampness?	O No	O Yes	
Within the past 12 months, were you ever worried whether your food would run out before you got money to buy more?	O No	O Yes	
Within the past 12 months, did the food you bought not last, and you did not have money to get more?	O No	O Yes	
Alcohol and Drugs			
Does anyone in your household drink beer, wine, or liquor?	O No	O Yes	
Do you or other family members use marijuana, cocaine, pain pills, narcotics, or other controlled substances?	O No	O Yes	
Social Connections With Family, Friends, Child Care, Home Visitation Program Staff, and Others			
Do you have child care or an adult you trust to care for your child?	O Yes	O No	
Have you talked about your thoughts on feeding, sleeping, discipline, and media use with your caregiver?	O Yes	O No	
Do you participate in activities outside your home? These may be social, religious, volunteer, or recreational programs.	O Yes	O No	

CARING FOR YOUR CHILD

If your child is upset, do you help distract him using another activity, book, or toy?	O Yes	O No
Do you use time-outs as a way to manage your child's behavior?	O Yes	O No
Do you have any questions about what to do when you become angry or frustrated with your child?	O No	O Yes
Does your family regularly make time for reading, playing, and talking together?	O Yes	O No
Do you eat together as a family?	O Yes	O No
Do you have regular mealtimes and snack times?	O Yes	O No
Do you help your child feel comfortable around new people and new situations?	O Yes	O No
Do you have regular nap time and bedtime routines for your child, such as reading books and brushing teeth?		O No

PATIENT NAME:	DATE:	
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12 MONTH VISIT		
CARING FOR YOUR CHILD (CONTINUED)		
Does your child watch TV or play on a tablet or smartphone? If yes, how much time each day? hours	O No	O Yes
Have you made a family media use plan to help you balance media use with other family activities?	O Yes	O No
FEEDING YOUR CHILD		
Does your child try feeding herself using a spoon?	O Yes	O No
Does your child drink from a cup?	O Yes	O No
Do you give your child small, hard foods such as peanuts and popcorn?	O No	O Yes
Do you give your child round foods such as hot dogs, raw carrots, grapes, and grape tomatoes?	O No	O Yes
Do you include your child in family meals?	O Yes	O No
Have you begun to serve your child cow's milk?	O Yes	O No
Does your child eat vegetables and fruits?	O Yes	O No
Does your child eat foods rich in protein, such as eggs, lean meat, chicken, or fish?	O Yes	O No
Do you let your child decide what and how much to eat?	O Yes	O No
HEALTHY TEETH		
Do you brush your child's teeth with a smear of fluoridated toothpaste 2 times a day using a soft toothbru	sh? O Yes	O No
SAFETY		
Car and Home Safety		
Is your child fastened securely in a rear-facing car safety seat in the back seat every time he rides in a ve	hicle? O Yes	O No
Are you having any problems using your car safety seat?	O No	O Yes
Do you have a gate at the top and bottom of all stairs in your home?	O Yes	O No
Is the mattress in your child's crib set on the lowest setting to prevent falls?	O Yes	O No
Do you keep household cleaners, chemicals, and medicines locked up and out of your child's sight and re	each? O Yes	O No
Do all your electrical outlets have covers?	O Yes	O No
Do you keep sharp objects, plastic bags, and electrical or drapery cords out of your child's reach?	O Yes	O No
Do you keep your child away from the stove, fireplaces, and space heaters?	O Yes	O No
Are your TVs, bookcases, and dressers secured to the wall so they cannot fall over and hurt your child?	O Yes	O No
Water and Sun Safety		
Do you always stay within arm's reach of your child when he is in the bath?	O Yes	O No
Do you have a swimming pool, pond, or lake in or near your home?	O No	O Yes
Do you put a hat on your child and apply sunscreen on her when you go outside?	O Yes	O No
Pets		

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

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



Do you own a pet?

If so, does your child interact with the pet?

The information contained in this questionnaire should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances. Original questionnaire included as part of the *Bright Futures Tool and Resource Kit*, 2nd Edition.

The American Academy of Pediatrics (AAP) does not review or endorse any modifications made to this questionnaire and in no event shall the AAP be liable for any such changes.

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O No

O No

O NA

O Yes

O Yes