

American Academy of Pediatrics



# BRIGHT FUTURES PREVISIT QUESTIONNAIRE

## 2½ YEAR 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. **Child Development screening is also part of this visit.** 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:

Blank space for describing concerns or questions.

### TELL US ABOUT YOUR CHILD AND FAMILY.

What excites or delights you most about your child?

Blank space for describing what excites or delights the child.

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

Blank space for describing special health care needs.

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

Blank space for describing major changes in life.

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

Blank space for describing medical problems in relatives.

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

Do you have specific concerns about your child's development, learning, or behavior?  No  Yes, describe:

Blank space for describing specific concerns about development, learning, or behavior.

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

- Urinate in a potty or toilet.
- Poke food with a fork.
- Wash and dry hands.
- Play pretend with toys or dolls.
- Ask you to watch by saying, "Look at me!"
- Use pronouns, such as "me," "his," and "our," correctly.
- Explain the reasons for things, such as needing a sweater when it's cold.
- Name at least one color.
- Walk up steps, using one foot, then the other.
- Run well without falling.
- Copy a vertical line.
- Grasp a crayon with thumb and fingers instead of fist.
- Catch large balls.

## 2½ YEAR VISIT

### RISK ASSESSMENT

|                    |   |                           |                           |                              |
|--------------------|---|---------------------------|---------------------------|------------------------------|
| <b>Anemia</b>      | Does your child's diet include iron-rich foods, such as meat, iron-fortified cereals, or beans? | <input type="radio"/> Yes | <input type="radio"/> No  | <input type="radio"/> Unsure |
|                    | Do you ever struggle to put food on the table?  | <input type="radio"/> No  | <input type="radio"/> Yes | <input type="radio"/> Unsure |
| <b>Hearing</b>     | Do you have concerns about how your child hears?  | <input type="radio"/> No  | <input type="radio"/> Yes | <input type="radio"/> Unsure |
|                    | Do you have concerns about how your child speaks?   | <input type="radio"/> No  | <input type="radio"/> Yes | <input type="radio"/> Unsure |
| <b>Oral health</b> | Does your child have a dentist?   | <input type="radio"/> Yes | <input type="radio"/> No  | <input type="radio"/> Unsure |
|                    | Does your child's primary water source contain fluoride?  | <input type="radio"/> Yes | <input type="radio"/> No  | <input type="radio"/> Unsure |
| <b>Vision</b>      | Do you have concerns about how your child sees?   | <input type="radio"/> No  | <input type="radio"/> Yes | <input type="radio"/> Unsure |
|                    | Does your child have trouble with near or far vision?   | <input type="radio"/> No  | <input type="radio"/> Yes | <input type="radio"/> Unsure |
|                    | Do your child's eyes appear unusual or seem to cross?   | <input type="radio"/> No  | <input type="radio"/> Yes | <input type="radio"/> Unsure |
|                    | Do your child's eyelids droop or does one eyelid tend to close?                                 | <input type="radio"/> No  | <input type="radio"/> Yes | <input type="radio"/> Unsure |
|                    | Have your child's eyes ever been injured?   | <input type="radio"/> No  | <input type="radio"/> Yes | <input type="radio"/> Unsure |

### ANTICIPATORY GUIDANCE

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

#### FAMILY ROUTINES

|  |                           |                          |
|--|---------------------------|--------------------------|
| Does your family eat meals together?   | <input type="radio"/> Yes | <input type="radio"/> No |
| Do you have a regular bedtime routine for your child?  | <input type="radio"/> Yes | <input type="radio"/> No |
| Do you encourage family exercise, such as walking, swimming, dancing, or bicycling?                            | <input type="radio"/> Yes | <input type="radio"/> No |
| Does your family go to museums, zoos, and other educational places together?                                   | <input type="radio"/> Yes | <input type="radio"/> No |
| Do you and your partner participate in social activities? Do you do things with friends, away from the family? | <input type="radio"/> Yes | <input type="radio"/> No |
| Does everyone in your family follow the same routines and set the same limits for your child?                  | <input type="radio"/> Yes | <input type="radio"/> No |

#### LEARNING TO TALK AND COMMUNICATE

|  |                           |                           |
|--|---------------------------|---------------------------|
| Do you read to your child every day?   | <input type="radio"/> Yes | <input type="radio"/> No  |
| Do you use simple words when asking your child a question and give plenty of time for her to respond?                  | <input type="radio"/> Yes | <input type="radio"/> No  |
| Do you carefully listen to your child and, if necessary, offer the right words to help him make sure he is understood? | <input type="radio"/> Yes | <input type="radio"/> No  |
| Does your child become frustrated when others cannot understand what he says?  | <input type="radio"/> No  | <input type="radio"/> Yes |

#### GETTING ALONG WITH OTHERS

|   |                           |                          |
|---|---------------------------|--------------------------|
| Does your child play with other children?   | <input type="radio"/> Yes | <input type="radio"/> No |
| Do you allow your child to make choices such as what clothes to wear, what to eat, and what books to read?                    | <input type="radio"/> Yes | <input type="radio"/> No |
| How much time every day does your child spend watching TV or using computers, tablets, or smartphones?                        | _____ hours               |                          |
| If your child uses media, do you monitor the shows your child watches or activity she does?                                   | <input type="radio"/> Yes | <input type="radio"/> No |
| Has your family made a media use plan to help everyone balance time spent on media with other family and personal activities? | <input type="radio"/> Yes | <input type="radio"/> No |

#### GETTING READY FOR PRESCHOOL

|   |                           |                          |
|---|---------------------------|--------------------------|
| Do you have plans for child care or preschool in the next year? | <input type="radio"/> Yes | <input type="radio"/> No |
| Is your child a part of a regular playgroup?                    | <input type="radio"/> Yes | <input type="radio"/> No |
| Do you read books to your child about getting ready for school? | <input type="radio"/> Yes | <input type="radio"/> No |
| Are you encouraging toilet training?                            | <input type="radio"/> Yes | <input type="radio"/> No |
| Do you praise your child when she tries to use the potty?       | <input type="radio"/> Yes | <input type="radio"/> No |

Please print.

## 2½ YEAR VISIT

### SAFETY

| Car and Home Safety  |                           |                           |
|--|---------------------------|---------------------------|
| Is your child fastened securely in a car safety seat in the back seat every time he rides in a vehicle?                              | <input type="radio"/> Yes | <input type="radio"/> No  |
| Does everyone in the vehicle always use a lap and shoulder seat belt, booster seat, or car safety seat?                              | <input type="radio"/> Yes | <input type="radio"/> No  |
| Do you have a working smoke detector on every level of your home?  | <input type="radio"/> Yes | <input type="radio"/> No  |
| Do you test the batteries once a month?  | <input type="radio"/> Yes | <input type="radio"/> No  |
| Do you have an emergency escape plan in case of a fire?  | <input type="radio"/> Yes | <input type="radio"/> No  |
| Do you keep matches out of your child's sight and reach?   | <input type="radio"/> Yes | <input type="radio"/> No  |
| Do you keep your child away from the stove, grills, fireplaces, and space heaters?   | <input type="radio"/> Yes | <input type="radio"/> No  |
| Outdoor Safety   |                           |                           |
| When your child plays outside, do you make sure that he stays within fences and gates?   | <input type="radio"/> Yes | <input type="radio"/> No  |
| Does your child always wear a bike helmet when she rides on a tricycle, in a towed bike trailer, or in a seat on an adult's bicycle? | <input type="radio"/> Yes | <input type="radio"/> No  |
| Do you keep your child away from moving machines, lawn mowers, driveways, and streets?   | <input type="radio"/> Yes | <input type="radio"/> No  |
| Have you taught your child to be careful around dogs, especially if they are eating or you don't know them?                          | <input type="radio"/> Yes | <input type="radio"/> No  |
| Do you have a swimming pool, pond, or lake near your home?   | <input type="radio"/> No  | <input type="radio"/> Yes |
| Do you always put sunscreen on your child when she plays outside?  | <input type="radio"/> Yes | <input type="radio"/> 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>.

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®



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.

© 2019 American Academy of Pediatrics. All rights reserved.