CLEAR FORM

PATIENT NAME: _____ DATE: _____

Please print.

American Academy of Pediatrics

BRIGHT FUTURES PREVISIT QUESTIONNAIRE

9 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. 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 child's or 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

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

Check off each of the items that are true for your child.

- ☐ Shows the ability to get along with others and control his emotions
- ☐ Chooses to eat healthy foods and participate in physical activity every day
- ☐ Forms caring, supportive relationships with family members, other adults, and peers

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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
	Does your child eat a vegetarian diet (does not eat red meat, chicken, fish, or seafood)?	O No	O Yes	O Unsure
	If your child is a vegetarian (does not eat red meat, chicken, fish, or seafood), does your child take an iron supplement?	O Yes	O No	O Unsure
	Do you ever struggle to put food on the table?	O No	O Yes	O Unsure
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
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
	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

Neighborhood and Family Violence		
Are there frequent reports of violence in your community or school?	O No	O Yes
Has your child ever been bullied or hurt physically by someone?	O No	O Yes
Has your child felt excluded or not a part of any group of friends?	O No	O Yes
Has your child ever told you she was touched in a way that made her uncomfortable or on her private parts?	O No	O Yes
Food Security		
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
Tobacco, E-cigarettes, Alcohol, and Drugs		
Is there anyone in your child's life whose alcohol or drug use concerns you?	O No	O Yes
Do any of your child's friends smoke, use or vape e-cigarettes, drink alcohol or beer, or use drugs?	O No	O Yes
Harm From the Internet		
Do you know about your child's Internet use?	O Yes	O No
Do you have rules for the Internet?	O Yes	O No
Have you installed an Internet safety filter on your computers, tablets, and smartphones?	O Yes	O No
Emotional Security and Self-esteem		
Does your child usually seem happy?	O Yes	O No
Are there things your child is really good at doing or is proud of?	O Yes	O No
Does your child have the chance to help others at home, at school, or in your community?	O Yes	O No

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9 YEAR VISIT

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

Connectedness With Family and Peers		
Do your family members get along well with each other?	O Yes	O No
Does your family do things together?	O Yes	O No
Does your child have chores or responsibilities at home?	O Yes	O No
Does your child have friends at school or in your neighborhood?	O Yes	O No

YOUR GROWING CHILD

Temper Problems, Setting Reasonable Limits, and Friends		
Has your child experienced any recent stresses at home or in school?	O No	O Yes
Do you have clear rules and expectations for your child?	O Yes	O No
When your child breaks the rules, are you consistent with consequences and discipline?	O Yes	O No
Do you help your child control his anger, deal with worries, and solve problems?	O Yes	O No
Have you and your child talked about how to say no to smoking, alcohol, and drug use?	O Yes	O No
Onset of Puberty and Sexual Safety		
Have you talked with your child about the body changes that occur during puberty?	O Yes	O No
Have you discussed privacy and body safety with your child?	O Yes	O No
Have you and your child talked about sex?	O Yes	O No
Does your child know to tell a trusted adult if someone touches her private parts or if someone encourages her to do other things that make her uncomfortable or she knows are wrong?	O Yes	O No

SCHOOL

Do you have concerns about your child's school experience?	O No	O Yes
Has your child missed more than 2 days of school in any month?	O No	O Yes
Does your child have any difficulties at school or get extra help in any subjects?	O No	O Yes
Does your child participate in activities outside of school?	O Yes	O No

STAYING HEALTHY

Healthy Teeth		
Does your child have a dentist?	O Yes	O No
Does your child brush and floss his teeth every day?	O Yes	O No
Does your child use a mouth guard when playing contact sports?	O Yes	O No
Does your child regularly drink soda, juice, or other sugar-sweetened drinks?	O No	O Yes
Nutrition		
Do you have any concerns about your child's weight?	O No	O Yes
Do you have any concerns about her eating? This includes drinking enough milk and eating vegetables and fruits.	O No	O Yes
Do you eat family meals together?	O Yes	O No
Do you hear your child talking about how he looks or dieting?	O No	O Yes
Physical Activity		
Is your child physically active at least 1 hour a day? This includes running, playing sports, or active play with friends.	O Yes	O No
Do you have any concerns about your child's physical activity level, such as it being either too much or too little?	O No	O Yes
Does your child have trouble going to sleep or does she wake up during the night?	O No	O Yes
How much time every day does your child spend watching TV, playing video games, or using computers, tablets, or smartphones (not counting schoolwork)?	_____ hours	
Does your child have a TV or an Internet-connected device in her bedroom?	O No	O Yes
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 No

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SAFETY

Car Safety		
Does your child always sit in a belt-positioning booster seat or lap and shoulder seat belt in the back seat every time he rides in a vehicle?	O Yes	O No
Does everyone in the vehicle always use a lap and shoulder seat belt?	O Yes	O No
Outdoor Safety		
Does your child always wear a helmet to protect her head when biking, skating, or doing other outdoor activities?	O Yes	O No
Does your child know how to swim?	O Yes	O No
Does your child know to always have an adult watching him in the water and never to swim alone?	O Yes	O No
Does your child always use sunscreen when playing outside?	O Yes	O No
Knowing Your Child's Friends and Their Families		
Do you know your child's friends and their families?	O Yes	O No
Does your child know how to get help in an emergency if you are not there?	O Yes	O No
Gun Safety		
Does anyone in your home or the homes where your child spends time have a gun?	O No	O Yes
If yes, is the gun unloaded and locked up?	O Yes	O No
If yes, is the ammunition stored and locked up separately from the gun?	O Yes	O No
Have you talked with your child about gun safety?	O Yes	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®