PATIENT NAME: _____ **DATE:** _____

American Academy of Pediatrics

BRIGHT FUTURES PREVISIT QUESTIONNAIRE
18 MONTH VISIT

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 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 tasks that your child is able to do.

- ☐ Engage with others for play.
- ☐ Help dress and undress himself.
- ☐ Point to pictures in a book.
- ☐ Point to an interesting object to draw your attention to it.
- ☐ Turn and look at an adult if something new happens.
- ☐ Begin to scoop with a spoon.
- ☐ Use words to ask for help.
- ☐ Identify at least 2 body parts.
- ☐ Name at least 5 familiar objects, such as ball or milk.
- ☐ Walk up with 2 feet per step with his hand held.
- ☐ Sit in a small chair.
- ☐ Carry a toy while walking.
- ☐ Scribble spontaneously.
- ☐ Throw a small ball a few feet while standing.

RISK ASSESSMENT

Anemia	Does your child's diet include iron-rich foods, such as meat, iron-fortified cereals, or beans?	○ Yes	○ No	○ Unsure
	Do you ever struggle to put food on the table?	○ No	○ Yes	○ Unsure
Hearing	Do you have concerns about how your child hears?	○ No	○ Yes	○ Unsure
	Do you have concerns about how your child speaks?	○ No	○ Yes	○ 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 was renovated in the past 6 months?	○ No	○ Yes	○ Unsure
Oral health	Does your child have a dentist?	○ Yes	○ No	○ Unsure
	Does your child's primary water source contain fluoride?	○ Yes	○ No	○ Unsure
Vision	Do you have concerns about how your child sees?	○ No	○ Yes	○ Unsure
	Do your child's eyes appear unusual or seem to cross?	○ No	○ Yes	○ Unsure
	Do your child's eyelids droop or does one eyelid tend to close?	○ No	○ Yes	○ Unsure
	Have your child's eyes ever been injured?	○ No	○ Yes	○ Unsure

SAFETY

Car and Home Safety		
Is your child fastened securely in a rear-facing car safety seat in the back seat car every time he rides in a vehicle?	○ Yes	○ No
Does everyone in the car always use a lap and shoulder seat belt, booster seat, or car safety seat?	○ Yes	○ No
Do you have emergency phone numbers near every telephone and in your cell phone for rapid dial?	○ Yes	○ No
Do you keep cigarettes, lighters, matches, and alcohol out of your child's sight and reach?	○ Yes	○ No

Do you keep your child away from the stove, fireplaces, and space heaters?	○ Yes	○ No
Do you have a gate at the top and bottom of all stairs in your home?	○ Yes	○ No
Do you keep furniture away from windows and use operable window guards on windows on the second floor and higher? (Operable means that, in case of an emergency, an adult can open the window.)	○ Yes	○ No
Are your TVs, bookcases, and dressers secured to the wall so they cannot fall over and hurt your child?	○ Yes	○ No
Do you have any questions about other ways to keep your home safe?	○ No	○ Yes
Sun Protection		
Do you apply sunscreen on your child whenever she plays outside?	○ Yes	○ No
Gun Safety		
Does anyone in your home or the homes where your child spends time have a gun?	○ No	○ Yes
If yes, is the gun unloaded and locked up?	○ Yes	○ No
If yes, is the ammunition stored and locked up separately from the gun?	○ Yes	○ No