



BRIGHT FUTURES PREVISIT QUESTIONNAIRE

2 YEAR 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.

- | | | |
|---|--|---|
| <input type="checkbox"/> Play with other children and express interest in their play. | <input type="checkbox"/> Follow a 2-step command (such as "Pick it up and put it away"). | <input type="checkbox"/> Run with coordination. |
| <input type="checkbox"/> Take off some clothing. | <input type="checkbox"/> Name at least 5 body parts. | <input type="checkbox"/> Climb up a ladder at a playground. |
| <input type="checkbox"/> Scoop well with a spoon. | <input type="checkbox"/> Speak so strangers can understand 50% of what he says. | <input type="checkbox"/> Stack objects. |
| <input type="checkbox"/> Use 50 words. | <input type="checkbox"/> Kick a ball. | <input type="checkbox"/> Turn book pages. |
| <input type="checkbox"/> Combine 2 words into a short phrase or sentence. | <input type="checkbox"/> Jump off the ground with 2 feet. | <input type="checkbox"/> Use his hands to turn objects. |
| | | <input type="checkbox"/> Draw lines. |

RISK ASSESSMENT

Anemia	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
Dyslipidemia	Does your child have parents, grandparents, or aunts or uncles who have had a stroke or heart problem before age 55 (male) or 65 (female)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Does your child have a parent with elevated blood cholesterol level (240 mg/dL or higher) or who is taking cholesterol medication?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
Hearing	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
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?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
Oral health	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
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)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Has your child had close contact with a person who has tuberculosis disease or who has had a positive tuberculosis test result?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Is your child infected with HIV?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
Vision	Do you have concerns about how your child sees?	<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

SAFETY

Car Safety

Is your child fastened securely in a rear-facing 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

Outdoor Safety

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
Do you live near any backyard swimming pools, hot tubs, or spas?	<input type="radio"/> No	<input type="radio"/> Yes

Gun Safety

Does anyone in your home or the homes where your child spends time have a gun?	<input type="radio"/> No	<input type="radio"/> Yes
If yes, is the gun unloaded and locked up?	<input type="radio"/> Yes	<input type="radio"/> No
If yes, is the ammunition stored and locked up separately from the gun?	<input type="radio"/> Yes	<input type="radio"/> No