PATIENT NAME: _____ **DATE:** _____

American Academy of Pediatrics

BRIGHT FUTURES PREVISIT QUESTIONNAIRE
4 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.

- ☐ Go to the bathroom and have a bowel movement by himself.
- ☐ Dress and undress without much help.
- ☐ Play make-believe.
- ☐ Answer questions such as "What do you do when you are cold?" and "When you are sleepy?"
- ☐ Use 4-word sentences.
- ☐ Speak so strangers can understand 100% of what she says.
- ☐ Draw pictures you recognize.
- ☐ Follow simple rules when playing board or card games.
- ☐ Tell you a story from a book.
- ☐ Skip on one foot.
- ☐ Climb stairs, using one foot, then the other, without support.
- ☐ Draw a person with at least 3 body parts.
- ☐ Draw a simple cross.
- ☐ Unbutton and button medium-sized buttons.
- ☐ Grasp a pencil with a thumb and fingers instead of her fist.

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
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)?	○ No	○ Yes	○ Unsure
	Does your child have a parent with elevated blood cholesterol level (240 mg/dL or higher) or who is taking cholesterol medication?	○ 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
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)?	○ No	○ Yes	○ Unsure
	Has your child had close contact with a person who has tuberculosis disease or who has had a positive tuberculosis test result?	○ No	○ Yes	○ Unsure
	Is your child infected with HIV?	○ No	○ Yes	○ Unsure

Opportunities to Socialize With Other Children		
Is your child interested in other children?	O Yes	O No
Does your child have a chance to play with other children in playgroups or at preschool?	O Yes	O No
Does your child have a best friend?	O Yes	O No
Do you praise your child when she is good or has finished a task?	O Yes	O No
Early Childhood Programs and Preschool		
Does your child attend preschool?	O Yes	O No
Are you happy with your child care or preschool arrangement?	O Yes	O No
Do you visit your child's preschool and participate in activities there?	O Yes	O No
Readiness for School		
Do you have any concerns about your child starting school in the coming year?	O No	O Yes
Are you doing things to get your child ready for preschool? This could include reading together and going to the library, the park, the zoo, and other places.	O Yes	O No

LIMITING TV AND PROMOTING PHYSICAL ACTIVITY

How much time every day does your child spend watching TV or using computers, tablets, or smartphones?	_____ hours	
Does your child have a TV or an Internet-connected device in her bedroom?	O No	O Yes
Has your family made a media use plan to help everyone balance time spent on media with other family and personal activities?	O Yes	O No
Does your child play actively for at least 1 hour a day?	O Yes	O No
Does your child play with other children?	O Yes	O No
Are you physically active together as a family, such as going for walks or playing in the park?	O Yes	O No

SAFETY

Car Safety		
Is your child fastened securely in a car safety seat or belt-positioning booster seat in the back seat every time he rides in a vehicle?	O Yes	O No
Does everyone else in the vehicle always use a lap and shoulder seat belt, booster seat, or car safety seat?	O Yes	O No
Outdoor Safety		
Do you watch your child closely when she plays outside, especially near streets and driveways?	O Yes	O No
Are there swimming pools in your neighborhood?	O No	O Yes
Are you planning to have your child learn to swim?	O Yes	O No
Does your child always wear an US Coast Guard–approved life jacket when on a boat?	O Yes	O No
Does your child always use sunscreen when he plays outside?	O Yes	O No
Pets		
Do you own a pet?	O No	O Yes
Have you taught your child how to behave around animals so she does not get bitten or scratched?	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