CLEAR FORM

PATIENT NAME: _____ DATE: _____

Please print.

American Academy of Pediatrics

BRIGHT FUTURES PREVISIT QUESTIONNAIRE

15 MONTH VISIT

Bright Futures™

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 tasks that your child is able to do.

- ☐ Imitate scribbling.
- ☐ Drink from cup with little spilling.
- ☐ Point to ask for something or to get help.
- ☐ Look around when you say things such as "Where's your ball?" and "Where's your blanket?"
- ☐ Use 3 words other than names.
- ☐ Speak in sounds that seem like an unknown language.
- ☐ Follow directions that do not include a gesture.
- ☐ Squat to pick up objects.
- ☐ Crawl up a few steps.
- ☐ Run.
- ☐ Make marks with a crayon.
- ☐ Drop an object into and take the object out of a container.

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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
	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
Vision	Do you have concerns about how your child sees?	O No	O Yes	O Unsure
	Do your child's eyes appear unusual or seem to cross?	O No	O Yes	O Unsure
	Do your child's eyelids droop or does one eyelid tend to close?	O No	O Yes	O Unsure
	Have your child's eyes ever been injured?	O No	O Yes	O Unsure

ANTICIPATORY GUIDANCE

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

TALKING AND FEELING

Is your child learning new things?	O Yes	O No
Does your child show any worries or fears when meeting new people?	O No	O Yes
Do you take time for yourself?	O Yes	O No
Do you spend time alone with your partner?	O Yes	O No
Does your child point to something he wants and then watch to see if you see what he's doing?	O Yes	O No
Does she wave "bye-bye"?	O Yes	O No
Do you talk to, sing to, and look at books with your child every day?	O Yes	O No

SLEEP ROUTINES AND ISSUES

Does your child have a regular bedtime routine?	O Yes	O No
Does your child sleep well?	O Yes	O No
How many hours does your child sleep? _____ Daytime _____ Nighttime		
Does your child have a blanket, stuffed animal, or toy that he likes to sleep with?	O Yes	O No
Do you have a TV or an Internet-connected device in your child's bedroom?	O No	O Yes

TANTRUMS AND DISCIPLINE

Does your child have frequent tantrums?	O No	O Yes
If your child is upset, do you help distract her with another activity, book, or toy?	O Yes	O No
Do you set limits for your child?	O Yes	O No
Do other caregivers set the same limits for your child as you do?	O Yes	O No
Do you praise your child when he is being good?	O Yes	O No
Do you have any questions about what to do when you become angry or frustrated with your child?	O No	O Yes

HEALTHY TEETH

Has your child been to a dentist?	O Yes	O No
Do you brush your child's teeth with a smear of fluoridated toothpaste 2 times a day using a soft toothbrush?	O Yes	O No
Does your child use a bottle?	O No	O Yes

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SAFETY

Car and Home Safety		
Is your child fastened securely in a rear-facing car safety seat in the back seat every time she rides in a vehicle?	○ Yes	○ No
Does everyone in the vehicle always use a lap and shoulder seat belt, booster seat, or car safety seat?	○ Yes	○ No
Do you keep cleaners and medicines locked up and out of your child's sight and reach?	○ Yes	○ No
Do you have emergency phone numbers near every telephone and in your cell phone for rapid dial?	○ 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
Do you have a gate at the top and bottom of all stairs in your home?	○ 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?	○ Yes	○ No
Do you have working smoke alarms on every floor of your home?	○ Yes	○ No
Do you test the batteries once a month?	○ Yes	○ No
Do you have a fire escape plan?	○ Yes	○ 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®

Mankato Clinic

Health History
12-18 Months (15 Months)

Current Health History

A. Feeding/Nutrition:
   1. How does your child eat?
      a. __Excellent ___Well ___Fair ___ Poor
   2. Do you have any concerns about your child's eating? Yes or No
   3. Does your child use
      a. ___Bottle ___Sippy Cup ___Open cup
   4. Does your child drink:
      a. Milk? Yes or No - How much? ____
      b. Juice? Yes or No - How much? ____
      c. Water? Yes or No How much? ____

A. Elimination:
   1. How often does your child have a stool (messy pants)?
      _____
   2. Do you have any concerns with voiding (wet pants)? Yes or No