CLEAR FORM

PATIENT NAME: _____ DATE: _____

Please print.

American Academy of Pediatrics

BRIGHT FUTURES PREVISIT QUESTIONNAIRE

18 MONTH 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. **Child Development and Autism Spectrum Disorder screenings are also part of this visit.** 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.

- ☐ 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.

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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
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?	O No	O Yes	O Unsure
Oral health	Does your child have a dentist?	O Yes	O No	O Unsure
	Does your child's primary water source contain fluoride?	O Yes	O No	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?

YOUR CHILD'S BEHAVIOR

Do you praise your child for good behavior?		O Yes	O No
If your child is upset, do you help distract him with another activity, book, or toy?		O Yes	O No
Do other caregivers set the same limits for your child as you do?		O Yes	O No
Do you use time-outs as a way to manage your child's behavior?		O Yes	O No
Have you thought about toilet training?		O Yes	O No
If you are planning to have another baby, have you thought about how you will prepare your child?	O NA	O Yes	O No

TALKING AND COMMUNICATING

Do you read, sing, and talk with your child about what you are seeing and doing?	O Yes	O No
Does he wave "bye-bye"?	O Yes	O No
Do you use simple words to tell your child what to do?	O Yes	O No

YOUR CHILD AND TV

How much time every day does your child spend watching TV or using computers, tablets, or smartphones?	_____ hours	
If your child uses media, do you monitor the shows your child watches or activity she does?	O Yes	O No

HEALTHY EATING

Do you provide a variety of vegetables, fruits, and other nutritious foods?	O Yes	O No
Does your child eat much food that you would describe as junk food?	O No	O Yes
Does your child drink water every day?	O Yes	O No
Is your child willing to try new foods?	O Yes	O No

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?	O Yes	O No
Does everyone in the car always use a lap and shoulder seat belt, booster seat, or car safety seat?	O Yes	O No
Do you have emergency phone numbers near every telephone and in your cell phone for rapid dial?	O Yes	O No
Do you keep cigarettes, lighters, matches, and alcohol out of your child's sight and reach?	O Yes	O No

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18 MONTH VISIT

SAFETY (*CONTINUED*)

Car and Home Safety (*continued*)		
Do you keep your child away from the stove, fireplaces, and space heaters?	O Yes	O No
Do you have a gate at the top and bottom of all stairs in your home?	O Yes	O 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.)	O Yes	O No
Are your TVs, bookcases, and dressers secured to the wall so they cannot fall over and hurt your child?	O Yes	O No
Do you have any questions about other ways to keep your home safe?	O No	O Yes
Sun Protection		
Do you apply sunscreen on your child whenever she plays outside?	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

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 (18 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