CLEAR FORM

PATIENT NAME: _____ DATE: _____

Please print.

American Academy of Pediatrics

BRIGHT FUTURES PREVISIT QUESTIONNAIRE

2 YEAR 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. **Autism Spectrum Disorder screening is 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.

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

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2 YEAR VISIT

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

YOUR FAMILY'S HEALTH AND WELL-BEING

Intimate Partner Violence		
Do you always feel safe in your home?	O Yes	O No
Has your partner, or another significant person in your life, ever hit, kicked, or shoved you, or physically hurt you or your child?	O No	O Yes
Living Situation and Food Security		
Is permanent housing a worry for you?	O No	O Yes
Do you have the things you need to take care of your child?	O Yes	O No
Does your home have enough heat, hot water, electricity, and working appliances?	O Yes	O No
Within the past 12 months, were you ever worried whether your food would run out before you got money to buy more?	O No	O Yes
Within the past 12 months, did the food you bought not last, and you did not have money to get more?	O No	O Yes
Alcohol and Drugs		
Does anyone in your household drink beer, wine, or liquor?	O No	O Yes
Do you or other family members use marijuana, cocaine, pain pills, narcotics, or other controlled substances?	O No	O Yes
Taking Care of Yourself		
Do you take time for yourself?	O Yes	O No
Do you and your partner spend time alone together?	O Yes	O No
Do you and your family do activities together?	O Yes	O No
Do you have someone you can turn to if you need to talk about problems?	O Yes	O No

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2 YEAR VISIT

YOUR CHILD'S BEHAVIOR

Is your child learning new things?	O Yes	O No
Do you spend time alone with your child doing something that he likes to do?	O Yes	O No
Do you encourage other family members and caregivers to be consistent, patient, and calm with your child?	O Yes	O No
Do you show your child how to be physically active every day by playing and being active with her?	O Yes	O No
Does your child play with other children?	O Yes	O No
How much time every day does your child spend watching TV or using computers, tablets, or smartphones?	_____ hours	

TALKING AND YOUR CHILD

Does your child have ways to tell you what he wants?	O Yes	O No
Do you use simple words when asking your child a question or telling her what to do?	O Yes	O No
Do you give your child plenty of time to respond?	O Yes	O No
Do you sing songs and talk with your child about the things you do together?	O Yes	O No
Do you read to your child or look at books together every day?	O Yes	O No

TOILET TRAINING

Is your child interested in using the toilet?	O Yes	O No
Does your child tell you when he has a bowel movement?	O Yes	O No
Is your child dry for about 2 hours at a time?	O Yes	O No
Does your child know the difference between being wet and dry?	O Yes	O No
Do you help your child wash her hands after going to the bathroom?	O Yes	O No

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?	O Yes	O No
Does everyone in the vehicle always use a lap and shoulder seat belt, booster seat, or car safety seat?	O Yes	O 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?	O Yes	O No
Do you keep your child away from moving machines, lawn mowers, driveways, and streets?	O Yes	O No
Do you live near any backyard swimming pools, hot tubs, or spas?	O No	O Yes
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®

The information contained in this questionnaire should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances. Original questionnaire included as part of the *Bright Futures Tool and Resource Kit,* 2nd Edition.

The American Academy of Pediatrics (AAP) does not review or endorse any modifications made to this questionnaire and in no event shall the AAP be liable for any such changes.

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Mankato Clinic

Health History
24 and 30 Months (2 Years)

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. Is your child toilet trained? Yes or No
   2. How often does your child have a stool? _____
   3. Any constipation? Yes or No
   4. Diarrhea? Yes or No