CLEAR FORM

PATIENT NAME: _____ DATE: _____

Please print.

American Academy of Pediatrics

BRIGHT FUTURES PREVISIT QUESTIONNAIRE

2½ 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. **Child Development 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.

- ☐ Urinate in a potty or toilet.
- ☐ Poke food with a fork.
- ☐ Wash and dry hands.
- ☐ Play pretend with toys or dolls.
- ☐ Ask you to watch by saying, "Look at me!"
- ☐ Use pronouns, such as "me," "his," and "our," correctly.
- ☐ Explain the reasons for things, such as needing a sweater when it's cold.
- ☐ Name at least one color.
- ☐ Walk up steps, using one foot, then the other.
- ☐ Run well without falling.
- ☐ Copy a vertical line.
- ☐ Grasp a crayon with thumb and fingers instead of fist.
- ☐ Catch large balls.

PATIENT NAME: _____ DATE: _____

Please print.

2½ 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
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
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
	Does your child have trouble with near or far vision?	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?

FAMILY ROUTINES

Does your family eat meals together?	O Yes	O No
Do you have a regular bedtime routine for your child?	O Yes	O No
Do you encourage family exercise, such as walking, swimming, dancing, or bicycling?	O Yes	O No
Does your family go to museums, zoos, and other educational places together?	O Yes	O No
Do you and your partner participate in social activities? Do you do things with friends, away from the family?	O Yes	O No
Does everyone in your family follow the same routines and set the same limits for your child?	O Yes	O No

LEARNING TO TALK AND COMMUNICATE

Do you read to your child every day?	O Yes	O No
Do you use simple words when asking your child a question and give plenty of time for her to respond?	O Yes	O No
Do you carefully listen to your child and, if necessary, offer the right words to help him make sure he is understood?	O Yes	O No
Does your child become frustrated when others cannot understand what he says?	O No	O Yes

GETTING ALONG WITH OTHERS

Does your child play with other children?	O Yes	O No
Do you allow your child to make choices such as what clothes to wear, what to eat, and what books to read?	O Yes	O No
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
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

GETTING READY FOR PRESCHOOL

Do you have plans for child care or preschool in the next year?	O Yes	O No
Is your child a part of a regular playgroup?	O Yes	O No
Do you read books to your child about getting ready for school?	O Yes	O No
Are you encouraging toilet training?	O Yes	O No
Do you praise your child when she tries to use the potty?	O Yes	O No

PATIENT NAME: _____ DATE: _____

Please print.

2½ YEAR VISIT

SAFETY

Car and Home Safety		
Is your child fastened securely in a 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
Do you have a working smoke detector on every level of your home?	O Yes	O No
Do you test the batteries once a month?	O Yes	O No
Do you have an emergency escape plan in case of a fire?	O Yes	O No
Do you keep matches out of your child's sight and reach?	O Yes	O No
Do you keep your child away from the stove, grills, fireplaces, and space heaters?	O Yes	O No
Outdoor Safety		
When your child plays outside, do you make sure that he stays within fences and gates?	O Yes	O No
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
Have you taught your child to be careful around dogs, especially if they are eating or you don't know them?	O Yes	O No
Do you have a swimming pool, pond, or lake near your home?	O No	O Yes
Do you always put sunscreen on your child when she plays outside?	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
24 and 30 Months (2.5 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