PATIENT NAME: ______________________________ **DATE:** ____________

Please print.

American Academy of Pediatrics

BRIGHT FUTURES PREVISIT QUESTIONNAIRE
3 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. 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.

- ☐ Go to the bathroom and urinate by herself.
- ☐ Put on a coat, jacket, or shirt by himself.
- ☐ Eat by herself.
- ☐ Begin to play make-believe.
- ☐ Play and share with others.
- ☐ Use 3-word sentences.
- ☐ Speak so strangers can understand 75% of what he says.
- ☐ Tell you a story from a book or TV.
- ☐ Compare things using words such as *bigger* and *shorter*.
- ☐ Understand simple prepositions, such as *on* or *under*.
- ☐ Pedal a tricycle.
- ☐ Climb on and off a couch or chair.
- ☐ Jump forward.
- ☐ Draw a single circle.
- ☐ Draw a person with head and one other body part.
- ☐ Cut with child scissors.

Downloaded from http://publications.aap.org/toolkits/book/chapter-pdf/1513486/bftk_previsit_questionnaire_3year.pdf
by Children's Health Center, Mankato Clinic user

PATIENT NAME: ______________________ **DATE:** __________

Please print.

3 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
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

ANTICIPATORY GUIDANCE

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

YOUR FAMILY'S HEALTH AND WELL-BEING

Living Situation and Food Security		
Do you have enough heat, hot water, electricity, and working appliances?	O Yes	O No
Do you have problems with bugs, rodents, peeling paint or plaster, mold, or dampness?	O No	O Yes
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
Positive Family Interactions		
Are your family members loving and affectionate with one another?	O Yes	O No
Do you praise your child when he is being good?	O Yes	O No
Do you have ways to constructively handle anger and settle disputes in your family?	O Yes	O No
Does everyone who cares for your child set the same limits for your child?	O Yes	O No
Do you allow your child to make choices, such as what clothes to wear or what books to read?	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
Taking Care of Yourself		
Do you take time for yourself?	O Yes	O No
Do you feel you are able to balance family and work?	O Yes	O No
Do you spend time alone with your partner?	O Yes	O No

PLAYING WITH SIBLINGS AND PEERS

Does your child engage in fantasy play with dolls, toy animals, or blocks?	O Yes	O No
Do you spend time alone with your child doing things you both enjoy?	O Yes	O No
Does your child have chances to play with other children (such as on playdates and at preschool)?	O Yes	O No

Downloaded from http://publications.aap.org/toolkits/book/chapter-pdf/1513486/bftk_previsit_questionnaire_3year.pdf
by Children's Health Center, Mankato Clinic user

PATIENT NAME: ______________________________ **DATE:** __________

Please print.

3 YEAR VISIT

PLAYING WITH SIBLINGS AND PEERS (*CONTINUED*)

When your child plays with other children, do you help him learn how to take turns?		O Yes	O No
If you have other children, do they get along with each other?	O NA	O Yes	O No
Are you expecting or thinking about having another child?		O No	O Yes

READING AND TALKING WITH YOUR CHILD

Do you read, sing songs, or play word games with your child every day?	O Yes	O No
When you are reading together, do you ask your child questions about the pictures or story in the book?	O Yes	O No
Do you encourage your child to tell you about his day?	O Yes	O No
Does your family speak more than one language at home?	O No	O Yes

EATING HEALTHY AND BEING ACTIVE

Nutritious Foods		
Does your child drink water every day?	O Yes	O No
How many ounces of milk does your child drink on most days?	_____ oz	
Do you offer your child a variety of foods, including vegetables, fruits, and foods rich in protein, such as meat, eggs, chicken, or fish?	O Yes	O No
Is your child willing to try new flavors and food textures?	O Yes	O No
Do you let your child decide how much to eat and when to stop?	O Yes	O No
Promoting Physical Activity and Limiting TV		
Are you physically active together as a family, such as going on walks or playing in the park?	O Yes	O No
Does your child play actively for at least 1 hour a day?	O Yes	O No
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

SAFETY

Car and Home Safety		
Is your child buckled securely in a car safety seat in the back seat every time he rides in a vehicle?	O Yes	O No
Are you having any problems with your car seat?	O No	O Yes
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 cut foods such as grapes and hot dogs into small pieces to prevent choking?	O Yes	O No
Does your child play in a driveway or close to the street?	O No	O Yes
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
Water Safety		
Are there swimming pools near your home?	O No	O Yes
Do you always stay within arm's reach of your child when he is in or near water?	O Yes	O No
Does your child always wear an US Coast Guard–approved life jacket when on a boat?	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

Downloaded from http://publications.aap.org/toolkits/book/chapter-pdf/1513486/bftk_previsit_questionnaire_3year.pdf
by Children's Health Center, Mankato Clinic user

3 YEAR VISIT

SAFETY (*CONTINUED*)

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.

© 2019 American Academy of Pediatrics. All rights reserved.

Downloaded from http://publications.aap.org/toolkits/book/chapter-pdf/1513486/bftk_previsit_questionnaire_3year.pdf
by Children's Health Center, Mankato Clinic user

Health History
3 Years

Current Health History

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
   5. Any concerns with urination? Yes or No

B. Dental:
   1. Do you and your child brush their teeth? _____________

MC2852A (11/24)