



Bright Futures Previsit Questionnaire 3 Year Visit

For us to provide you and your child with the best possible health care, we would like to know how things are going. Please answer all of 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?

We are interested in answering your questions. Please check off the boxes for the topics you would like to discuss the most today.

Family Support	<input type="checkbox"/> Balancing work and family	<input type="checkbox"/> Giving your child choices	<input type="checkbox"/> Having time alone with your partner
	<input type="checkbox"/> Being consistent with your child	<input type="checkbox"/> Showing affection to your child	<input type="checkbox"/> How to use time-outs
	<input type="checkbox"/> How your child is getting along with brothers and sisters	<input type="checkbox"/> Taking time for yourself	<input type="checkbox"/> Your child's weight
Reading and Talking With Your Child	<input type="checkbox"/> How to get your child interested in reading	<input type="checkbox"/> What to talk about with your child	
Playing With Others	<input type="checkbox"/> Fun games to play with your child	<input type="checkbox"/> Playing and getting along with other children	
Your Active Child	<input type="checkbox"/> How to keep your child active	<input type="checkbox"/> How much TV is too much TV	
Safety	<input type="checkbox"/> Car safety seats	<input type="checkbox"/> Staying safe outside	<input type="checkbox"/> Crossing the street safely
	<input type="checkbox"/> Gun safety	<input type="checkbox"/> Preventing falls from windows	

Questions About Your Child

Have any of your child's relatives developed new medical problems since your last visit? If yes, please describe: Yes No Unsure

Hearing	Do you have concerns about how your child hears?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Do you have concerns about how your child speaks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Lead	Does your child have a sibling or playmate who has or had lead poisoning?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Does your child live in or regularly visit a house or child care facility built before 1978 that is being or has recently been (within the past 6 months) renovated or remodeled?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Does your child live in or regularly visit a house or child care facility built before 1950?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Tuberculosis	Was your child born in a country at high risk for tuberculosis (countries other than the United States, Canada, Australia, New Zealand, or Western Europe)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Has your child traveled (had contact with resident populations) for longer than 1 week to a country at high risk for tuberculosis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Has a family member or contact had tuberculosis or a positive tuberculin skin test?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Is your child infected with HIV?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Anemia	Do you ever struggle to put food on the table?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Does your child's diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unsure
Oral Health	Does your child have a dentist?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unsure
	Does your child's primary water source contain fluoride?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unsure

Does your child have any special health care needs? No Yes, describe:

Have there been any major changes in your family lately? Move Job change Separation Divorce Death in the family Any other changes?

Does your child live with anyone who uses tobacco or spend time in any place where people smoke? No Yes

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.

- | | | |
|---|---|--|
| <input type="checkbox"/> Stacks 6 small blocks | <input type="checkbox"/> Pretend play, such as playing house or school | <input type="checkbox"/> Toilet trained during the day |
| <input type="checkbox"/> Throws a ball overhand | <input type="checkbox"/> Has a conversation with 2 or 3 sentences together | <input type="checkbox"/> Draws a person with 2 body parts |
| <input type="checkbox"/> Balances on each foot | <input type="checkbox"/> Knows the name and use of cup, spoon, ball, and crayon | <input type="checkbox"/> Can help take care of himself by feeding and dressing |
| <input type="checkbox"/> Copies a circle | <input type="checkbox"/> Usually understandable | <input type="checkbox"/> Identifies herself as a girl or boy |
| <input type="checkbox"/> Names a friend | <input type="checkbox"/> Walks up the stairs switching feet | |



American Academy of Pediatrics



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