



Name: _____

Date: _____

Bright Futures Previsit Questionnaire 8 Year Visit

For us to provide 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.

School	<input type="checkbox"/> How your child is learning and doing in school	<input type="checkbox"/> Bullying	<input type="checkbox"/> After-school activities and care
	<input type="checkbox"/> Special education needs	<input type="checkbox"/> How your child acts	<input type="checkbox"/> Talking with your child's school
Your Growing Child	<input type="checkbox"/> How your child feels about herself	<input type="checkbox"/> Following rules	<input type="checkbox"/> Getting ready for puberty
	<input type="checkbox"/> Your child dealing with his problems	<input type="checkbox"/> Becoming more independent	<input type="checkbox"/> Being angry
Staying Healthy	<input type="checkbox"/> Your child's weight	<input type="checkbox"/> 1 hour of physical activity daily	<input type="checkbox"/> Playing sports
	<input type="checkbox"/> Drinking enough water	<input type="checkbox"/> How much your child should eat at one time	<input type="checkbox"/> TV time
Healthy Teeth	<input type="checkbox"/> Regular dentist visits	<input type="checkbox"/> Brushing teeth twice daily	<input type="checkbox"/> Flossing daily
Safety	<input type="checkbox"/> Booster seats	<input type="checkbox"/> Helmets and sports safety	<input type="checkbox"/> Swimming safety
	<input type="checkbox"/> Knowing your child's computer use	<input type="checkbox"/> Knowing your child's friends and their families	<input type="checkbox"/> Wearing sunscreen
	<input type="checkbox"/> Smoke-free house and cars	<input type="checkbox"/> Preventing sexual abuse	<input type="checkbox"/> Gun safety

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

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
Dyslipidemia	Does your child have parents or grandparents who have had a stroke or heart problem before age 55?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Does your child have a parent with elevated blood cholesterol (240 mg/dL or higher) or who is taking cholesterol medication?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Anemia	Does your child eat a strict vegetarian diet?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	If your child is a vegetarian, does your child take an iron supplement?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<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

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 concerns about your child's development, learning, or behavior? No Yes, describe: _____

Check off each of the following that are true for your child.

- | | | |
|--|---|--|
| <input type="checkbox"/> Eats healthy meals and snacks | <input type="checkbox"/> Participates in an after-school activity | <input type="checkbox"/> Does chores when asked |
| <input type="checkbox"/> Has friends | <input type="checkbox"/> Is vigorously active for 1 hour a day | <input type="checkbox"/> Gets along with friends |
| <input type="checkbox"/> Is doing well in school | | |



American Academy of Pediatrics



The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate. Original document included as part of Bright Futures Tool and Resource Kit. Copyright © 2010 American Academy of Pediatrics. All Rights Reserved. The American Academy of Pediatrics does not review or endorse any materials made to this document and in no event shall the AAP be liable for any such changes.

DEDICATED TO THE HEALTH OF ALL CHILDREN™