



Bright Futures Previsit Questionnaire 5 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.

Ready for School	<input type="checkbox"/> Your child's fears about school <input type="checkbox"/> After-school care <input type="checkbox"/> Talking with your child's teacher <input type="checkbox"/> Your child's friends <input type="checkbox"/> Bullying <input type="checkbox"/> Your child feeling sad
Your Child and Family	<input type="checkbox"/> Family time together <input type="checkbox"/> Your child's chores <input type="checkbox"/> Your child handling his feelings <input type="checkbox"/> Your child being angry
Staying Healthy	<input type="checkbox"/> Your child's weight <input type="checkbox"/> Eating fruits <input type="checkbox"/> Eating vegetables <input type="checkbox"/> Eating whole grains <input type="checkbox"/> Getting enough calcium <input type="checkbox"/> 1 hour of physical activity per day
Healthy Teeth	<input type="checkbox"/> Regular dentist visits <input type="checkbox"/> Brushing teeth twice daily <input type="checkbox"/> Flossing daily
Safety	<input type="checkbox"/> Street safety <input type="checkbox"/> Booster seats <input type="checkbox"/> Always wearing safety helmets <input type="checkbox"/> Swimming safety <input type="checkbox"/> Sunscreen <input type="checkbox"/> Preventing sexual abuse <input type="checkbox"/> Fire escape and fire drill plan <input type="checkbox"/> Carbon monoxide alarms in your home <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

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
Anemia	Is your child infected with HIV?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	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

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"/> Listens well and follows simple instructions | <input type="checkbox"/> Draws a person with 6 body parts | <input type="checkbox"/> Balances on 1 foot |
| <input type="checkbox"/> Can tell a story with full sentences | <input type="checkbox"/> Copies squares, triangles | <input type="checkbox"/> Hops, skips, climbs |
| <input type="checkbox"/> Counts to 10 | <input type="checkbox"/> Writes some letters and numbers | <input type="checkbox"/> Ties a knot |
| <input type="checkbox"/> Names at least 4 colors | | |



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