



Bright Futures Previsit Questionnaire

18 Month Visit

For us to provide you and your baby 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.

Your Child and Family	<input type="checkbox"/> Taking time for yourself <input type="checkbox"/> Being a role model <input type="checkbox"/> Your child getting along with brothers and sisters <input type="checkbox"/> Family time together <input type="checkbox"/> Having another child <input type="checkbox"/> Getting your child to try new foods <input type="checkbox"/> Your child's weight
Your Child's Behavior	<input type="checkbox"/> How your child acts <input type="checkbox"/> How to tell your child she did a good job <input type="checkbox"/> Fun activities for your child <input type="checkbox"/> Your child being scared in new places <input type="checkbox"/> Setting limits and discipline
Talking and Hearing	<input type="checkbox"/> How your child talks <input type="checkbox"/> Helping your child to learn
Toilet Training	<input type="checkbox"/> Knowing when your child is ready <input type="checkbox"/> How to toilet train
Safety	<input type="checkbox"/> Car safety seats <input type="checkbox"/> Preventing falls, fires, and poisoning <input type="checkbox"/> Gun safety <input type="checkbox"/> Keeping your child safe outside

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
Vision	Do you have concerns about how your child sees?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Does your child hold objects close when trying to focus?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Do your child's eyes appear unusual or seem to cross, drift, or be lazy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Do your child's eyelids droop or does one eyelid tend to close?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Have your child's eyes ever been injured?	<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 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"/> Knows name of favorite book | <input type="checkbox"/> Walks up steps | <input type="checkbox"/> Points to 1 body part |
| <input type="checkbox"/> Laughs in response to others | <input type="checkbox"/> Speaks 6 words | <input type="checkbox"/> Stacks 2 small blocks |
| <input type="checkbox"/> Runs | <input type="checkbox"/> Uses spoon and cup without spilling most of the time | <input type="checkbox"/> Helps around the house |



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TO BE FILLED OUT BY PROVIDER

ACCOMPANIED BY/INFORMANT	PREFERRED LANGUAGE	DATE/TIME	Name
DRUG ALLERGIES	CURRENT MEDICATIONS		ID NUMBER
WEIGHT (%) <small>See growth chart.</small>	LENGTH (%)	WEIGHT FOR LENGTH (%)	HEAD CIRC (%)
TEMPERATURE	BIRTH DATE	AGE M F	

History

<input type="checkbox"/> Previsit Questionnaire reviewed	<input type="checkbox"/> Child has special health care needs
<input type="checkbox"/> Child has a dental home	

Concerns and questions None Addressed (see other side)

Follow-up on previous concerns None Addressed (see other side)

Interval history None Addressed (see other side)

Medication Record reviewed and updated

Social/Family History

See Initial History Questionnaire. No interval change

Family situation

Parents working outside home: Mother Father

Child care: Yes No Type _____

Changes since last visit _____

Review of Systems

See Initial History Questionnaire and Problem List.

No interval change

Changes since last visit _____

Nutrition: Breast Bottle Cup

Milk _____ Ounces per day _____

Solid foods _____

Juice _____

Source of water _____ Vitamins/Fluoride _____

Elimination: NL _____

Sleep: NL _____

Behavior: NL _____

Activity (playtime, no TV): NL _____

Development

Structured developmental screen NL Tool _____

Autism-specific screen NL Tool _____

Developmental Surveillance (if not reviewed in Previsit Questionnaire)

<input type="checkbox"/> SOCIAL-EMOTIONAL <ul style="list-style-type: none"> • Helps in the house • Laughs in response to others 	<input type="checkbox"/> COMMUNICATIVE <ul style="list-style-type: none"> • Speaks 6 words <input type="checkbox"/> COGNITIVE • Knows name of favorite book • Points to 1 body part 	<input type="checkbox"/> PHYSICAL DEVELOPMENT <ul style="list-style-type: none"> • Stacks 2 small blocks • Runs • Walks up steps • Uses spoon and cup without spilling most of the time
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Physical Examination

= NL

Bright Futures Priority

- EYES (red reflex, cover/uncover test)
- SKIN (nevi, café au lait, bruising)
- NEUROLOGIC (gait, coordination)
- TEETH (caries, white spots, staining)

Additional Systems

- GENERAL APPEARANCE
- HEAD/FONTANELLE
- EARS/APPEARS TO HEAR
- NOSE
- LUNGS
- MOUTH AND THROAT

- HEART
- Femoral pulses
- ABDOMEN
- GENITALIA
- Male/Testes down
- Female
- EXTREMITIES/HIPS
- BACK

Abnormal findings and comments

Assessment

Well child

Anticipatory Guidance

Discussed and/or handout given

<input type="checkbox"/> FAMILY SUPPORT <ul style="list-style-type: none"> • Family time • Time for self and other children • Reinforce limits • Prepare for new sibling (if necessary) • Smoke-free environment <input type="checkbox"/> CHILD DEVELOPMENT AND BEHAVIOR <ul style="list-style-type: none"> • Anticipate anxiety • Praise • Consistent discipline • Daily playtime 	<input type="checkbox"/> LANGUAGE PROMOTION/HEARING <ul style="list-style-type: none"> • Read, talk, and sing • Simple words • Feelings and emotions <input type="checkbox"/> TOILET TRAINING READINESS <ul style="list-style-type: none"> • Wait until child is ready • Reading books/praise 	<input type="checkbox"/> SAFETY <ul style="list-style-type: none"> • Car safety seat • Falls • Burns • Smoke detectors • Guns • Poisons
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Plan

Immunizations (See Vaccine Administration Record.)

Laboratory/Screening results _____

Referral to _____

Follow-up/Next visit _____

See other side

Print Name	Signature
PROVIDER 1	
PROVIDER 2	



**This American Academy of Pediatrics Visit Documentation Form is consistent with
*Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, 3rd Edition.***

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Bright Futures Parent Handout

18 Month Visit

Here are some suggestions from Bright Futures experts that may be of value to your family.

LANGUAGE PROMOTION/HEARING

Talking and Hearing

- Read and sing to your child often.
- Talk about and describe pictures in books.
- Use simple words with your child.
- Tell your child the words for her feelings.
- Ask your child simple questions, confirm her answers, and explain simply.
- Use simple, clear words to tell your child what you want her to do.

Your Child and Family

- Create time for your family to be together.
- Keep outings with a toddler brief—1 hour or less.
- Do not expect a toddler to share.
- Give older children a safe place for toys they do not want to share.
- Teach your child not to hit, bite, or hurt other people or pets.
- Your child may go from trying to be independent to clinging; this is normal.
- Consider enrolling in a parent-toddler playgroup.
- Ask us for help in finding programs to help your family.
- Prepare for your new baby by reading books about being a big brother or sister.
- Spend time with each child.
- Make sure you are also taking care of yourself.
- Tell your child when he is doing a good job.
- Give your toddler many chances to try a new food. Allow mouthing and touching to learn about them.
- Tell us if you need help with getting enough food for your family.

FAMILY SUPPORT

SAFETY

Safety

- Use a car safety seat in the back seat of all vehicles.

SAFETY

- Have your child's car safety seat rear-facing until your child is 2 years of age *or* until she reaches the highest weight or height allowed by the car safety seat's manufacturer.
- Everyone should always wear a seat belt in the car.
- Lock away poisons, medications, and lawn and cleaning supplies.
- Call Poison Help (1-800-222-1222) if you are worried your child has eaten something harmful.
- Place gates at the top and bottom of stairs and guards on windows on the second floor and higher.
- Move furniture away from windows.
- Watch your child closely when she is on the stairs.
- When backing out of the garage or driving in the driveway, have another adult hold your child a safe distance away so he is not run over.
- Never have a gun in the home. If you must have a gun, store it unloaded and locked with the ammunition locked separately from the gun.
- Prevent burns by keeping hot liquids, matches, lighters, and the stove away from your child.
- Have a working smoke detector on every floor.

Toilet Training

- Signs of being ready for toilet training include
 - Dry for 2 hours
 - Knows if he is wet or dry
 - Can pull pants down and up
 - Wants to learn
 - Can tell you if he is going to have a bowel movement
- Read books about toilet training with your child.

TOILET-TRAINING READINESS

TOILET-TRAINING READINESS

- Have the parent of the same sex as your child or an older brother or sister take your child to the bathroom.
- Praise sitting on the potty or toilet even with clothes on.
- Take your child to choose underwear when he feels ready to do so.

Your Child's Behavior

- Set limits that are important to you and ask others to use them with your toddler.
- Be consistent with your toddler.
- Praise your child for behaving well.
- Play with your child each day by doing things she likes.
- Keep time-outs brief. Tell your child in simple words what she did wrong.
- Tell your child what to do in a nice way.
- Change your child's focus to another toy or activity if she becomes upset.
- Parenting class can help you understand your child's behavior and teach you what to do.
- Expect your child to cling to you in new situations.

CHILD DEVELOPMENT AND BEHAVIOR

What to Expect at Your Child's 2 Year Visit

We will talk about

- Your talking child
- Your child and TV
- Car and outside safety
- Toilet training
- How your child behaves

Poison Help: 1-800-222-1222

Child safety seat inspection:
1-866-SEATCHECK; seatcheck.org



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