



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"/> Preventing falls from windows <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

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



DEDICATED TO THE HEALTH OF ALL CHILDREN™

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 modifications made to this document and in no event shall the AAP be liable for any such changes.

TO BE FILLED OUT BY PROVIDER

ACCOMPANIED BY/INFORMANT	PREFERRED LANGUAGE	DATE/TIME
DRUG ALLERGIES	CURRENT MEDICATIONS	
WEIGHT (%) <small>See growth chart.</small>	HEIGHT (%)	BMI (%)
BLOOD PRESSURE		TEMPERATURE

Name
ID NUMBER
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 _____

Preschool: Yes No _____

Changes since last visit _____

Review of Systems

See Initial History Questionnaire and Problem List.

No interval change

Changes since last visit _____

Nutrition _____

Elimination: NL _____

Toilet training: Yes In process _____

Sleep: NL _____

Behavior/Temperament: NL _____

Physical activity

Play time (60 min/d) Yes No

Screen time (<2 h/d) Yes No

Parent-child interaction

Communication: NL _____

Choices: NL _____

Cooperation: NL _____

Appropriate responses to behavior: NL _____

Development (if not reviewed in Previsit Questionnaire)

<input type="checkbox"/> SOCIAL-EMOTIONAL	<input type="checkbox"/> COMMUNICATIVE	<input type="checkbox"/> PHYSICAL DEVELOPMENT
• Self-care skills	• 2-3 sentences	• Builds tower (6-8 blocks)
• Imaginative play	• Usually understandable	• Stands on 1 foot
	• Names a friend	• Throws ball overhand
	<input type="checkbox"/> COGNITIVE	• Walks upstairs alternating feet
	• Names objects	• Copies circle
	• Knows if boy or girl	• Draws person (2 body parts)
		• Toilet trained during day

Physical Examination

= NL

Bright Futures Priority

EYES (red reflex, cover/uncover test)

TEETH (caries, white spots, staining)

NEUROLOGIC (language, speech, social interaction)

Additional Systems

GENERAL APPEARANCE

HEAD

EARS

NOSE

MOUTH AND THROAT

NECK

LUNGS

HEART

ABDOMEN

GENITALIA

EXTREMITIES

BACK

SKIN

Abnormal findings and comments _____

Assessment

Well child

Anticipatory Guidance

Discussed and/or handout given

<input type="checkbox"/> FAMILY SUPPORT	<input type="checkbox"/> PLAYING WITH PEERS	<input type="checkbox"/> SAFETY
• Show affection	• Encourage appropriate play	• Car safety seat
• Manage anger	• Encourage fantasy play	• Supervise play near streets, cars
• Reinforce appropriate behavior	• Encourage play with peers	• Safety near windows
• Reinforce limits	<input type="checkbox"/> PROMOTING PHYSICAL ACTIVITY	• Guns
• Find time for yourself	• Family exercise, activities	
<input type="checkbox"/> ENCOURAGING LITERACY ACTIVITIES	• Limit screen time—maximum 1-2 hours/day	
• Read, sing, play	• No TV in bedroom	
• Talk about pictures in books		
• Encourage child to talk		

Plan

Immunizations (See Vaccine Administration Record.)

Laboratory/Screening results: Vision _____

Referral to _____

Follow-up/Next visit _____

See other side

Print Name	Signature
PROVIDER 1	
PROVIDER 2	





Bright Futures Parent Handout 3 Year Visit

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

ENCOURAGING LITERACY ACTIVITIES

Reading and Talking With Your Child

- Read books, sing songs, and play rhyming games with your child each day.
- Reading together and talking about a book's story and pictures helps your child learn how to read.
- Use books as a way to talk together.
- Look for ways to practice reading everywhere you go, such as stop signs or signs in the store.
- Ask your child questions about the story or pictures. Ask him to tell a part of the story.
- Ask your child to tell you about his day, friends, and activities.

PROMOTING PHYSICAL ACTIVITY

Your Active Child

Apart from sleeping, children should not be inactive for longer than 1 hour at a time.

- Be active together as a family.
- Limit TV, video, and video game time to no more than 1–2 hours each day.
- No TV in your child's bedroom.
- Keep your child from viewing shows and ads that may make her want things that are not healthy.
- Be sure your child is active at home and preschool or child care.
- Let us know if you need help getting your child enrolled in preschool or Head Start.

FAMILY SUPPORT

Family Support

- Take time for yourself and to be with your partner.
- Parents need to stay connected to friends, their personal interests, and work.
- Be aware that your parents might have different parenting styles than you.
- Give your child the chance to make choices.
- Show your child how to handle anger well—time alone, respectful talk, or being active. Stop hitting, biting, and fighting right away.
- Reinforce rules and encourage good behavior.
- Use time-outs or take away what's causing a problem.
- Have regular playtimes and mealtimes together as a family.

SAFETY

Safety

- Use a forward-facing car safety seat in the back seat of all vehicles.
- Switch to a belt-positioning booster seat when your child outgrows her forward-facing seat.
- Never leave your child alone in the car, house, or yard.
- Do not let young brothers and sisters watch over your child.
- Your child is too young to cross the street alone.
- Make sure there are operable window guards on every window on the second floor and higher. Move furniture away from windows.
- 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. Ask if there are guns in homes where your child plays. If so, make sure they are stored safely.
- Supervise play near streets and driveways.

PLAYING WITH PEERS

Playing With Others

Playing with other preschoolers helps get your child ready for school.

- Give your child a variety of toys for dress-up, make-believe, and imitation.
- Make sure your child has the chance to play often with other preschoolers.
- Help your child learn to take turns while playing games with other children.

What to Expect at Your Child's 4 Year Visit

We will talk about

- Getting ready for school
- Community involvement and safety
- Promoting physical activity and limiting TV time
- Keeping your child's teeth healthy
- Safety inside and outside
- How to be safe with adults

Poison Help: 1-800-222-1222

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



American Academy of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN™

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 modifications made to this document and in no event shall the AAP be liable for any such changes.