



Bright Futures Previsit Questionnaire 4 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.

| | | |
|---------------------------------|---|--|
| Getting Ready for School | <input type="checkbox"/> How your child is doing in preschool | <input type="checkbox"/> How your child does playing with other children |
| | <input type="checkbox"/> If your child is ready for grade school | <input type="checkbox"/> How your child is speaking |
| | <input type="checkbox"/> Your child's feelings | <input type="checkbox"/> Your child's weight |
| Healthy Habits | <input type="checkbox"/> How your child is eating | <input type="checkbox"/> Brushing teeth |
| | <input type="checkbox"/> How your child is sleeping | |
| TV and Media | <input type="checkbox"/> How much TV is too much TV | <input type="checkbox"/> Encouraging your child to be active |
| Your Community | <input type="checkbox"/> Fun activities to do outside the home | <input type="checkbox"/> Educational programs in the community |
| | <input type="checkbox"/> Getting along with other children and adults | <input type="checkbox"/> Feeling safe in your home |
| | <input type="checkbox"/> Playing safely with other children | <input type="checkbox"/> Answering questions about your child's body |
| Safety | <input type="checkbox"/> Car safety seats and booster seats | <input type="checkbox"/> Being safe outside |
| | <input type="checkbox"/> Gun safety | <input type="checkbox"/> Keeping your child safe from sexual abuse |

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

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:

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

Check off each of the tasks that your child is able to do.

- Builds a tower of 8 small blocks
- Copies a cross
- Can balance on each foot
- Names 4 colors
- Hops on 1 foot
- Draws a person with 3 parts
- Dresses herself, including buttons
- Plays pretend by himself and with others
- Knows her name, age, and whether she is a boy or girl
- Plays board or card games
- Other people can understand what he is saying
- Brushes own teeth



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 | Name | | |
| DRUG ALLERGIES | | CURRENT MEDICATIONS | ID NUMBER | | |
| WEIGHT (%) <small>See growth chart.</small> | HEIGHT (%) | BMI (%) | BLOOD PRESSURE | TEMPERATURE | BIRTH DATE |
| | | | | | AGE |

History

Previsit Questionnaire reviewed

Child has a dental home

Child has special health care needs

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 trained: Yes No _____

Sleep: NL _____

Behavior/Temperament: NL _____

Physical activity

Play time (60 min/d) Yes No

Screen time (<2 h/d) Yes No

Toxic exposure: Passive smoking 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"/> COGNITIVE | <input type="checkbox"/> PHYSICAL DEVELOPMENT |
| • Interactions with peers | • Names 4 colors | • Hops on 1 foot |
| • Fantasy play | • Draws person | • Balances on 1 foot for 2 seconds |
| <input type="checkbox"/> COMMUNICATIVE | • (3 body parts) | • Builds tower (8 blocks) |
| • Usually understandable | • Plays board/card games | • Copies a cross |
| • Knows name, age, gender | | • Brushes own teeth |
| | | • Dresses self |

Physical Examination

= NL

Bright Futures Priority

NEUROLOGIC

FINE MOTOR SKILLS

GROSS MOTOR SKILLS

LANGUAGE

SPEECH

THOUGHT PROCESS

TEETH (caries, white spots, staining)

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"/> SCHOOL READINESS | <input type="checkbox"/> TV/MEDIA | <input type="checkbox"/> SAFETY |
| • Model behavior | • Limit TV/video to 1–2 hours/day | • Appropriately restrained in all vehicles |
| • Be sensitive to child's feelings | • No TV in bedroom | • Supervise all outdoor play |
| • Encourage play with other children | <input type="checkbox"/> CHILD AND FAMILY INVOLVEMENT | • Guns |
| • Consider preschool | • Community activities | |
| • Daily reading | • Expect curiosity about body—answer questions using proper terms | |
| • Talk with child | <input type="checkbox"/> HEALTHY PERSONAL HABITS | |
| <input type="checkbox"/> HEALTHY PERSONAL HABITS | • Calm bedtime routine | • Safety rules with adults |
| • Calm bedtime routine | • Brush teeth twice daily | • Good and bad touches |
| • Brush teeth twice daily | • Daily physical activity | • How to seek help when needed |

Plan

Immunizations (See Vaccine Administration Record.)

Laboratory/Screening results: Vision Hearing

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.***

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.
Copyright © 2010 American Academy of Pediatrics. All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, recording, or otherwise, without prior written permission from the publisher.



Bright Futures Parent Handout 4 Year Visit

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

Getting Ready for School

- Ask your child to tell you about her day, friends, and activities.
- Read books together each day and ask your child questions about the stories.
- Take your child to the library and let her choose books.
- Give your child plenty of time to finish sentences.
- Listen to and treat your child with respect. Insist that others do so as well.
- Model apologizing and help your child to do so after hurting someone's feelings.
- Praise your child for being kind to others.
- Help your child express her feelings.
- Give your child the chance to play with others often.
- Consider enrolling your child in a preschool, Head Start, or community program. Let us know if we can help.

DEVELOPING HEALTHY PERSONAL HABITS

Healthy Habits

- Have relaxed family meals without TV.
- Create a calm bedtime routine.
- Have the child brush his teeth twice each day using a pea-sized amount of toothpaste with fluoride.
- Have your child spit out toothpaste, but do not rinse his mouth with water.

Safety

- Use a forward-facing car safety seat or booster seat in the back seat of all vehicles.
- Switch to a belt-positioning booster seat when your child reaches the weight or height limit for her car safety seat, her shoulders are above the top harness slots, or her ears come to the top of the car safety seat.
- Never leave your child alone in the car, house, or yard.
- Do not permit your child to cross the street alone.
- 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.

SAFETY

Your Community

- Stay involved in your community. Join activities when you can.
- Use correct terms for all body parts as your child becomes interested in how boys and girls differ.
- Teach your child about how to be safe with other adults.
 - No one should ask for a secret to be kept from parents.
 - No one should ask to see private parts.
 - No adult should ask for help with his private parts.
- Know that help is available if you don't feel safe.

TELEVISION AND MEDIA

TV and Media

- Be active together as a family often.
- Limit TV time to no more than 2 hours per day.
- Discuss the TV programs you watch together as a family.
- No TV in the bedroom.
- Create opportunities for daily play.
- Praise your child for being active.

What to Expect at Your Child's 5 and 6 Year Visits

We will talk about

- Keeping your child's teeth healthy
- Preparing for school
- Dealing with child's temper problems
- Eating healthy foods and staying active
- Safety outside and inside

Poison Help: 1-800-222-1222

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

SCHOOL READINESS

CHILD AND FAMILY INVOLVEMENT AND SAFETY IN THE COMMUNITY



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.