

American Academy of Pediatrics



# BRIGHT FUTURES PREVISIT QUESTIONNAIRE

## 18 MONTH VISIT

To provide you and your child with the best possible health care, we would like to know how things are going. Please answer all the questions. **Child Development and Autism Spectrum Disorder screenings are also part of this visit.** 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?  No  Yes, describe:

Blank space for describing concerns or questions.

### TELL US ABOUT YOUR CHILD AND FAMILY.

What excites or delights you most about your child?

Blank space for describing what excites or delights the child.

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

Blank space for describing special health care needs.

Have there been major changes lately in your child's or family's life?  No  Yes, describe:

Blank space for describing major changes in life.

Have any of your child's relatives developed new medical problems since your last visit?  No  Yes  Unsure If yes or unsure, please describe:

Blank space for describing medical problems in relatives.

Does your child live with anyone who smokes or spend time in places where people smoke or use e-cigarettes?  No  Yes  Unsure

### YOUR GROWING AND DEVELOPING CHILD

Do you have specific concerns about your child's development, learning, or behavior?  No  Yes, describe:

Blank space for describing specific concerns about development, learning, or behavior.

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

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Engage with others for play.                                 | <input type="checkbox"/> Turn and look at an adult if something new happens.     | <input type="checkbox"/> Walk up with 2 feet per step with his hand held. |
| <input type="checkbox"/> Help dress and undress himself.                              | <input type="checkbox"/> Begin to scoop with a spoon.                            | <input type="checkbox"/> Sit in a small chair.                            |
| <input type="checkbox"/> Point to pictures in a book.                                 | <input type="checkbox"/> Use words to ask for help.                              | <input type="checkbox"/> Carry a toy while walking.                       |
| <input type="checkbox"/> Point to an interesting object to draw your attention to it. | <input type="checkbox"/> Identify at least 2 body parts.                         | <input type="checkbox"/> Scribble spontaneously.                          |
|   | <input type="checkbox"/> Name at least 5 familiar objects, such as ball or milk. | <input type="checkbox"/> Throw a small ball a few feet while standing.    |

Please print.

## 18 MONTH VISIT

### RISK ASSESSMENT

<b>Anemia</b>	Does your child's diet include iron-rich foods, such as meat, iron-fortified cereals, or beans?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unsure
	Do you ever struggle to put food on the table?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
<b>Hearing</b>	Do you have concerns about how your child hears?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Do you have concerns about how your child speaks?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
<b>Lead</b>	Does your child live in or visit a home or child care facility with an identified lead hazard or a home built before 1960 that is in poor repair or was renovated in the past 6 months?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
<b>Oral health</b>	Does your child have a dentist?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unsure
	Does your child's primary water source contain fluoride?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unsure
<b>Vision</b>	Do you have concerns about how your child sees?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Do your child's eyes appear unusual or seem to cross?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Do your child's eyelids droop or does one eyelid tend to close?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Have your child's eyes ever been injured?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure

### ANTICIPATORY GUIDANCE

How are things going for you, your child, and your family?

#### YOUR CHILD'S BEHAVIOR

Do you praise your child for good behavior?	<input type="radio"/> Yes	<input type="radio"/> No
If your child is upset, do you help distract him with another activity, book, or toy?	<input type="radio"/> Yes	<input type="radio"/> No
Do other caregivers set the same limits for your child as you do?	<input type="radio"/> Yes	<input type="radio"/> No
Do you use time-outs as a way to manage your child's behavior?	<input type="radio"/> Yes	<input type="radio"/> No
Have you thought about toilet training?	<input type="radio"/> Yes	<input type="radio"/> No
If you are planning to have another baby, have you thought about how you will prepare your child?	<input type="radio"/> NA	<input type="radio"/> Yes <input type="radio"/> No

#### TALKING AND COMMUNICATING

Do you read, sing, and talk with your child about what you are seeing and doing?	<input type="radio"/> Yes	<input type="radio"/> No
Does he wave "bye-bye"?	<input type="radio"/> Yes	<input type="radio"/> No
Do you use simple words to tell your child what to do?	<input type="radio"/> Yes	<input type="radio"/> No

#### YOUR CHILD AND TV

How much time every day does your child spend watching TV or using computers, tablets, or smartphones?	_____ hours
If your child uses media, do you monitor the shows your child watches or activity she does?	<input type="radio"/> Yes <input type="radio"/> No

#### HEALTHY EATING

Do you provide a variety of vegetables, fruits, and other nutritious foods?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child eat much food that you would describe as junk food?	<input type="radio"/> No	<input type="radio"/> Yes
Does your child drink water every day?	<input type="radio"/> Yes	<input type="radio"/> No
Is your child willing to try new foods?	<input type="radio"/> Yes	<input type="radio"/> No

#### SAFETY

<b>Car and Home Safety</b>		
Is your child fastened securely in a rear-facing car safety seat in the back seat car every time he rides in a vehicle?	<input type="radio"/> Yes	<input type="radio"/> No
Does everyone in the car always use a lap and shoulder seat belt, booster seat, or car safety seat?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have emergency phone numbers near every telephone and in your cell phone for rapid dial?	<input type="radio"/> Yes	<input type="radio"/> No
Do you keep cigarettes, lighters, matches, and alcohol out of your child's sight and reach?	<input type="radio"/> Yes	<input type="radio"/> No

Please print.

## 18 MONTH VISIT

### SAFETY (CONTINUED)

<b>Car and Home Safety (continued)</b>		
Do you keep your child away from the stove, fireplaces, and space heaters?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have a gate at the top and bottom of all stairs in your home?	<input type="radio"/> Yes	<input type="radio"/> No
Do you keep furniture away from windows and use operable window guards on windows on the second floor and higher? (Operable means that, in case of an emergency, an adult can open the window.)	<input type="radio"/> Yes	<input type="radio"/> No
Are your TVs, bookcases, and dressers secured to the wall so they cannot fall over and hurt your child?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have any questions about other ways to keep your home safe?	<input type="radio"/> No	<input type="radio"/> Yes
<b>Sun Protection</b>		
Do you apply sunscreen on your child whenever she plays outside?	<input type="radio"/> Yes	<input type="radio"/> No
<b>Gun Safety</b>		
Does anyone in your home or the homes where your child spends time have a gun?	<input type="radio"/> No	<input type="radio"/> Yes
If yes, is the gun unloaded and locked up?	<input type="radio"/> Yes	<input type="radio"/> No
If yes, is the ammunition stored and locked up separately from the gun?	<input type="radio"/> Yes	<input type="radio"/> No

Consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, 4th Edition

For more information, go to <https://brightfutures.aap.org>.

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The information contained in this questionnaire should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances. Original questionnaire included as part of the *Bright Futures Tool and Resource Kit*, 2nd Edition.

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