Bright Futures Previsit Questionnaire
10 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.

School	❑ How your child is doing in school ❑ Homework ❑ Bullying
Your Growing Child	❑ How your child feels about herself ❑ Dealing with your child's anger ❑ Setting limits for your child ❑ Your child's friends ❑ Readiness for middle school ❑ Your child's sexuality ❑ Puberty
Staying Healthy	❑ Your child's weight ❑ Your child's body image ❑ Eating breakfast ❑ Limiting soft drinks ❑ Eating together as a family ❑ Drinking enough water ❑ Limiting high-fat food ❑ 1 hour of physical activity daily
Healthy Teeth	❑ Regular dentist visits ❑ Brushing teeth twice daily ❑ Flossing daily
Safety	❑ Bicycle and sports safety and helmets ❑ Car safety ❑ Swimming safety ❑ Sunscreen ❑ Knowing your child's friends and their families ❑ Preventing cigarette, alcohol, and drug use ❑ 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

_____

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)?	❑ Yes	❑ No	❑ Unsure
	Has your child traveled (had contact with resident populations) for longer than 1 week to a country at high risk for tuberculosis?	❑ Yes	❑ No	❑ Unsure
	Has a family member or contact had tuberculosis or a positive tuberculin skin test?	❑ Yes	❑ No	❑ Unsure
	Is your child infected with HIV?	❑ Yes	❑ No	❑ Unsure
Dyslipidemia	Does your child have parents or grandparents who have had a stroke or heart problem before age 55?	❑ Yes	❑ No	❑ Unsure
	Does your child have a parent with elevated blood cholesterol (240 mg/dL or higher) or who is taking cholesterol medication?	❑ Yes	❑ No	❑ Unsure
Anemia	Does your child eat a strict vegetarian diet?	❑ Yes	❑ No	❑ Unsure
	If your child is a vegetarian, does your child take an iron supplement?	❑ No	❑ Yes	❑ Unsure
	Does your child's diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?	❑ No	❑ Yes	❑ 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 following that are true for your child.

❑ Eats healthy meals and snacks
❑ Has friends
❑ Is doing well in school
❑ Feels good about himself
❑ Gets along with family
❑ Participates in an after-school activity
❑ Vigorously exercises for 1 hour a day
❑ Does chores when asked
❑ Getting chances to make own decisions
❑ Does an activity really well; describe: _____

_____

_____

_____

Bright Futures™
prevention and health promotion for infants, children, adolescents, and their families™

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™