



Barrow Pediatrics

and Adolescent Medicine

Please Follow These Instructions and Bring the Completed Form to Your Visit:

You can: 1) Use a Computer to complete your answers; or 2) Print out a blank form and use a pen to complete your answers. For those with access to a Computer, Option #1 will be the easiest method.

Option #1: Complete the Form using a Computer:

1. Open the downloaded PDF file and complete the Well-Check form using your Computer.
2. **Save all changes.** *You will lose your work* if you do not save your changes before printing out the completed form.
3. Print out the completed Well-Check form as a one-sided document on front-side of pages.
4. Bring the completed, printed form to our office at your appointment time.
5. Give the completed form to our receptionist.

Option #2: Print Out a Blank Form and use a pen to complete your answers.

1. Open the downloaded PDF file and print out a blank Well-Check form as a one-sided document on front-side of pages.
2. Complete the Well-Check form using a pen.
3. Bring the completed, printed form to our office at your appointment time.
4. Give the completed form to our receptionist.

NOTE: Parents of 11-12 year olds, 13-14 year olds, and 15-17 year olds have a separate Parent Well-Check form to complete for your child. This additional form is included in the downloaded PDF form file.

Thank You for Completing Your Child's Well-Check Form in Advance!

This will help reduce the wait time spent at your child's office visit.

American Academy of Pediatrics



BRIGHT FUTURES PREVISIT QUESTIONNAIRE

2½ YEAR 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 screening is 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:

TELL US ABOUT YOUR CHILD AND FAMILY.

What excites or delights you most about your child?

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

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

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

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:

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

- Urinate in a potty or toilet.
- Use pronouns, such as "me," "his," and "our," correctly.
- Run well without falling.
- Poke food with a fork.
- Explain the reasons for things, such as needing a sweater when it's cold.
- Copy a vertical line.
- Wash and dry hands.
- Name at least one color.
- Grasp a crayon with thumb and fingers instead of fist.
- Play pretend with toys or dolls.
- Walk up steps, using one foot, then the other.
- Catch large balls.
- Ask you to watch by saying, "Look at me!"

2½ YEAR VISIT

RISK ASSESSMENT

Anemia	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
Hearing	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
Oral health	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
Vision	Do you have concerns about how your child sees?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Does your child have trouble with near or far vision?	<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?

FAMILY ROUTINES

Does your family eat meals together?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have a regular bedtime routine for your child?	<input type="radio"/> Yes	<input type="radio"/> No
Do you encourage family exercise, such as walking, swimming, dancing, or bicycling?	<input type="radio"/> Yes	<input type="radio"/> No
Does your family go to museums, zoos, and other educational places together?	<input type="radio"/> Yes	<input type="radio"/> No
Do you and your partner participate in social activities? Do you do things with friends, away from the family?	<input type="radio"/> Yes	<input type="radio"/> No
Does everyone in your family follow the same routines and set the same limits for your child?	<input type="radio"/> Yes	<input type="radio"/> No

LEARNING TO TALK AND COMMUNICATE

Do you read to your child every day?	<input type="radio"/> Yes	<input type="radio"/> No
Do you use simple words when asking your child a question and give plenty of time for her to respond?	<input type="radio"/> Yes	<input type="radio"/> No
Do you carefully listen to your child and, if necessary, offer the right words to help him make sure he is understood?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child become frustrated when others cannot understand what he says?	<input type="radio"/> No	<input type="radio"/> Yes

GETTING ALONG WITH OTHERS

Does your child play with other children?	<input type="radio"/> Yes	<input type="radio"/> No
Do you allow your child to make choices such as what clothes to wear, what to eat, and what books to read?	<input type="radio"/> Yes	<input type="radio"/> No
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
Has your family made a media use plan to help everyone balance time spent on media with other family and personal activities?	<input type="radio"/> Yes	<input type="radio"/> No

GETTING READY FOR PRESCHOOL

Do you have plans for child care or preschool in the next year?	<input type="radio"/> Yes	<input type="radio"/> No
Is your child a part of a regular playgroup?	<input type="radio"/> Yes	<input type="radio"/> No
Do you read books to your child about getting ready for school?	<input type="radio"/> Yes	<input type="radio"/> No
Are you encouraging toilet training?	<input type="radio"/> Yes	<input type="radio"/> No
Do you praise your child when she tries to use the potty?	<input type="radio"/> Yes	<input type="radio"/> No

Please print.

2½ YEAR VISIT

SAFETY

Car and Home Safety		
Is your child fastened securely in a car safety seat in the back seat every time he rides in a vehicle?	<input type="radio"/> Yes	<input type="radio"/> No
Does everyone in the vehicle 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 a working smoke detector on every level of your home?	<input type="radio"/> Yes	<input type="radio"/> No
Do you test the batteries once a month?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have an emergency escape plan in case of a fire?	<input type="radio"/> Yes	<input type="radio"/> No
Do you keep matches out of your child's sight and reach?	<input type="radio"/> Yes	<input type="radio"/> No
Do you keep your child away from the stove, grills, fireplaces, and space heaters?	<input type="radio"/> Yes	<input type="radio"/> No
Outdoor Safety		
When your child plays outside, do you make sure that he stays within fences and gates?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child always wear a bike helmet when she rides on a tricycle, in a towed bike trailer, or in a seat on an adult's bicycle?	<input type="radio"/> Yes	<input type="radio"/> No
Do you keep your child away from moving machines, lawn mowers, driveways, and streets?	<input type="radio"/> Yes	<input type="radio"/> No
Have you taught your child to be careful around dogs, especially if they are eating or you don't know them?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have a swimming pool, pond, or lake near your home?	<input type="radio"/> No	<input type="radio"/> Yes
Do you always put sunscreen on your child when she plays outside?	<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>.

American Academy of Pediatrics

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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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