



# Bright Futures Previsit Questionnaire

## 12 Month 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?

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We are interested in answering your questions. Please check off the boxes for the topics you would like to discuss the most today.

<b>Family Support</b>	<input type="checkbox"/> Ways to manage your child's behavior	<input type="checkbox"/> Finding time for yourself	<input type="checkbox"/> Parent/family community activities			
<b>Establishing Routines</b>	<input type="checkbox"/> Nap time routines	<input type="checkbox"/> Bedtime routines	<input type="checkbox"/> Brushing teeth	<input type="checkbox"/> Starting family traditions		
<b>Feeding Your Child</b>	<input type="checkbox"/> Using a spoon and cup	<input type="checkbox"/> Healthy food choices	<input type="checkbox"/> How many meals or snacks a day	<input type="checkbox"/> How much your child should eat	<input type="checkbox"/> Change in appetite and growth	<input type="checkbox"/> Your child's weight
<b>Finding a Dentist</b>	<input type="checkbox"/> Your child's first dental checkup	<input type="checkbox"/> Brushing teeth twice daily	<input type="checkbox"/> Finger sucking, pacifiers, and bottles			
<b>Safety</b>	<input type="checkbox"/> Home safety indoors and outdoors	<input type="checkbox"/> Car safety seats	<input type="checkbox"/> Water safety	<input type="checkbox"/> Gun safety	<input type="checkbox"/> Older siblings watching your child	<input type="checkbox"/> Foods that might cause choking

### 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

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<b>Hearing</b>	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
<b>Vision</b>	Do you have concerns about how your child sees?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Does your child hold objects close when trying to focus?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Do your child's eyes appear unusual or seem to cross, drift, or be lazy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Do your child's eyelids droop or does one eyelid tend to close?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Have your child's eyes ever been injured?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
<b>Lead</b>	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
<b>Tuberculosis</b>	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
<b>Oral Health</b>	Do you know a dentist to whom you can bring your child?	<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:

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Have there been any major changes in your family lately?  Move  Job change  Separation  Divorce  Death in the family  Any other problems?

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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:

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

- |  |   |
|--|---|
| <input type="checkbox"/> Bangs toys together     | <input type="checkbox"/> Tries to make the same sounds you do |
| <input type="checkbox"/> Waves bye-bye           | <input type="checkbox"/> Looks at things you are looking at   |
| <input type="checkbox"/> Tries to do what you do | <input type="checkbox"/> Cries when you leave                 |
| <input type="checkbox"/> Stands alone            | <input type="checkbox"/> Hands you a book to read             |
| <input type="checkbox"/> Drinks from a cup       | <input type="checkbox"/> Follows simple directions            |
| <input type="checkbox"/> Speaks 1 to 2 words     | <input type="checkbox"/> Plays peekaboo                       |
| <input type="checkbox"/> Babbles                 |   |



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ACCOMPANIED BY/INFORMANT	PREFERRED LANGUAGE	DATE/TIME
DRUG ALLERGIES	CURRENT MEDICATIONS	
WEIGHT (%) <small>See growth chart.</small>	LENGTH (%)	WEIGHT FOR LENGTH (%)
		HEAD CIRC (%)

Name
ID NUMBER
TEMPERATURE
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

### Physical Examination

= NL

**Bright Futures Priority**

- EYES (red reflex, cover/uncover test)
- NEUROLOGIC (tone, strength, gait)
- TEETH (caries, white spots, staining)
- GENITALIA
  - MALE/TESTES DOWN
  - FEMALE

**Additional Systems**

- GENERAL APPEARANCE
- HEAD/FONTANELLE
- EARS/APPEARS TO HEAR
- NOSE
- MOUTH AND THROAT
- HEART
  - Femoral pulses
- EXTREMITIES/HIPS
- LUNGS
- ABDOMEN
- BACK
- SKIN

Abnormal findings and comments \_\_\_\_\_

### Social/Family History

See Initial History Questionnaire.  No interval change

**Family situation**

Parents working outside home:  Mother  Father

Child care:  Yes  No Type \_\_\_\_\_

Changes since last visit \_\_\_\_\_

### Assessment

Well child

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Review of Systems

See Initial History Questionnaire and Problem List.

No interval change

Changes since last visit \_\_\_\_\_

Nutrition:  Breast milk Minutes per feeding \_\_\_\_\_  
 Hours between feeding \_\_\_\_\_ Feedings per 24 hours \_\_\_\_\_  
 Formula Ounces per feeding \_\_\_\_\_  
 Source of water \_\_\_\_\_ Vitamins/Fluoride \_\_\_\_\_

Elimination:  NL \_\_\_\_\_

Sleep:  NL \_\_\_\_\_

Behavior:  NL \_\_\_\_\_

Activity (playtime, no TV):  NL \_\_\_\_\_

### Anticipatory Guidance

Discussed and/or handout given

- FAMILY SUPPORT
  - Time for self/partner
  - Community activities
  - Age-appropriate discipline
- ESTABLISHING ROUTINES
  - Family traditions
  - Nap and bedtime
- FEEDING AND APPETITE CHANGES
  - Self-feeding
  - Consistent meals/snacks
  - Variety of nutritious foods
  - Iron-fortified formula
- ESTABLISHING A DENTAL HOME
  - First dentist visit
  - Brush teeth twice a day
  - Limit bottle use (water only)
  - No bottle in bed
- SAFETY
  - Car safety seat
  - Poisons
  - Water
  - No supervision by young children
  - Sharp objects
  - Guns
  - Home safety
  - Falls

**Development** (if not reviewed in Previsit Questionnaire)

<input type="checkbox"/> SOCIAL-EMOTIONAL <ul style="list-style-type: none"> <li>• Waves bye-bye</li> <li>• Tries to do what you do</li> <li>• Cries when you leave</li> <li>• Plays peekaboo</li> <li>• Hands you a book to read</li> </ul>	<input type="checkbox"/> COMMUNICATIVE <ul style="list-style-type: none"> <li>• Speaks 1-2 words</li> <li>• Babbles</li> <li>• Tries to make the same sounds you do</li> <li>• Looks at things you are looking at</li> </ul>	<input type="checkbox"/> PHYSICAL DEVELOPMENT <ul style="list-style-type: none"> <li>• Bangs toys together</li> <li>• Pulls to stand</li> <li>• Stands alone</li> <li>• Drinks from a cup</li> </ul>
	<input type="checkbox"/> COGNITIVE <ul style="list-style-type: none"> <li>• Follows simple directions</li> </ul>	

### Plan

Immunizations (See Vaccine Administration Record.)

Laboratory/Screening results:  Hgb/Hct  Lead  Other \_\_\_\_\_

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.***

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# Bright Futures Parent Handout

## 12 Month Visit

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

### Family Support

- Try not to hit, spank, or yell at your child.
- Keep rules for your child short and simple.
- Use short time-outs when your child is behaving poorly.
- Praise your child for good behavior.
- Distract your child with something he likes during bad behavior.
- Play with and read to your child often.
- Make sure everyone who cares for your child gives healthy foods, avoids sweets, and uses the same rules for discipline.
- Make sure places your child stays are safe.
- Think about joining a toddler playgroup or taking a parenting class.
- Take time for yourself and your partner.
- Keep in contact with family and friends.

FAMILY SUPPORT

### Establishing Routines

- Your child should have at least one nap. Space it to make sure your child is tired for bed.
- Make the hour before bedtime loving and calm.
- Have a simple bedtime routine that includes a book.
- Avoid having your child watch TV and videos, and never watch anything scary.
- Be aware that fear of strangers is normal and peaks at this age.
- Respect your child's fears and have strangers approach slowly.
- Avoid watching TV during family time.
- Start family traditions such as reading or going for a walk together.

ESTABLISHING ROUTINES

### Feeding Your Child

- Have your child eat during family mealtime.
- Be patient with your child as she learns to eat without help.
- Encourage your child to feed herself.
- Give 3 meals and 2–3 snacks spaced evenly over the day to avoid tantrums.
- Make sure caregivers follow the same ideas and routines for feeding.
- Use a small plate and cup for eating and drinking.
- Provide healthy foods for meals and snacks.
- Let your child decide what and how much to eat.
- End the feeding when the child stops eating.
- Avoid small, hard foods that can cause choking—nuts, popcorn, hot dogs, grapes, and hard, raw veggies.

FEEDING AND APPETITE CHANGES

### Safety

- Have your child's car safety seat rear-facing until your child is 2 years of age *or* until she reaches the highest weight or height allowed by the car safety seat's manufacturer.
- Lock away poisons, medications, and lawn and cleaning supplies. Call Poison Help (1-800-222-1222) if your child eats nonfoods.
- Keep small objects, balloons, and plastic bags away from your child.
- Place gates at the top and bottom of stairs and guards on windows on the second floor and higher. Keep furniture away from windows.
- Lock away knives and scissors.
- Only leave your toddler with a mature adult.
- Near or in water, keep your child close enough to touch.

SAFETY

SAFETY

ESTABLISHING A DENTAL HOME

- Make sure to empty buckets, pools, and tubs when done.
- 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.

### Finding a Dentist

- Take your child for a first dental visit either by 12 months or as soon as you can after the first tooth erupts.
- Brush your child's teeth twice a day with a soft toothbrush. Use a small smear of fluoride toothpaste (the size of a grain of rice).
- If using a bottle, offer only water.

## What to Expect at Your Child's 15 Month Visit

### We will talk about

- Your child's speech and feelings
- Getting a good night's sleep
- Keeping your home safe for your child
- Temper tantrums and discipline
- Caring for your child's teeth

Poison Help: 1-800-222-1222

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



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