



Bright Futures Previsit Questionnaire 15 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?

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

Talking and Feeling	<input type="checkbox"/> How to handle your upset child when you leave	<input type="checkbox"/> Handling your frustrations with your child
	<input type="checkbox"/> Helping your child speak and learn	<input type="checkbox"/> Your child being scared of new people
	<input type="checkbox"/> Knowing how to give your child limited choices	
A Good Night's Sleep	<input type="checkbox"/> Your child's bedtime routine	<input type="checkbox"/> Waking up at night
Temper Tantrums and Discipline	<input type="checkbox"/> Temper tantrums	<input type="checkbox"/> How to discipline your child
	<input type="checkbox"/> Encouraging good behavior	
Healthy Teeth	<input type="checkbox"/> Stop using the bottle/pacifier	<input type="checkbox"/> Brushing teeth
	<input type="checkbox"/> First dentist visit	<input type="checkbox"/> Preventing tooth problems
Safety	<input type="checkbox"/> Car safety seats	<input type="checkbox"/> Preventing fires, burns, and poisoning
	<input type="checkbox"/> How to make your home safe on the inside and outside	

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

Hearing	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
Vision	Do you have concerns about how your child sees?	<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
	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

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 problems?

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 tasks that your child is able to do.

- | | | |
|---|--|---|
| <input type="checkbox"/> Tries to do what you do | <input type="checkbox"/> Drinks from a cup with very little spilling | <input type="checkbox"/> Helps in the house |
| <input type="checkbox"/> Bends down without falling | <input type="checkbox"/> Says 2 to 3 words | <input type="checkbox"/> Brings toys over to show you |
| <input type="checkbox"/> Walks well | <input type="checkbox"/> Listens to a story | <input type="checkbox"/> Follows simple commands |
| <input type="checkbox"/> Puts block in a cup | | |
| <input type="checkbox"/> Scribbles | | |

List what words your child says.



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ACCOMPANIED BY/INFORMANT	PREFERRED LANGUAGE	DATE/TIME
DRUG ALLERGIES	CURRENT MEDICATIONS	
WEIGHT (%)	LENGTH (%)	WEIGHT FOR LENGTH (%) HEAD CIRC (%)

See growth chart.

Name		
ID NUMBER		
TEMPERATURE	BIRTH DATE	AGE

<input type="checkbox"/>	M	<input type="checkbox"/>	F
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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

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 _____

Review of Systems

See Initial History Questionnaire and Problem List.

No interval change

Changes since last visit _____

Nutrition: Breast Bottle Cup

Milk _____ Ounces per day _____

Solid foods _____

Juice _____

Source of water: _____ Vitamins/Fluoride _____

Elimination: NL _____

Sleep: NL _____

Behavior: NL _____

Activity (playtime, no TV): NL _____

Development (if not reviewed in Previsit Questionnaire)

<input type="checkbox"/> SOCIAL-EMOTIONAL	<input type="checkbox"/> COMMUNICATIVE	<input type="checkbox"/> PHYSICAL
• Tries to do what you do	• Says 2 to 3 words	DEVELOPMENT
• Helps in the house	• Brings toys over to show you	• Bends down without falling
• Listens to a story	<input type="checkbox"/> COGNITIVE	• Walks well
	• Scribbles	• Puts block in a cup
	• Follows simple commands	• Drinks from a cup with very little spilling

Physical Examination

= NL

Bright Futures Priority

- EYES (red reflex, cover/uncover test)
- NEUROLOGIC
- TEETH (caries, white spots, staining)

Additional Systems

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

Abnormal findings and comments

Assessment

Well child

Anticipatory Guidance

<input type="checkbox"/> Discussed and/or handout given	<input type="checkbox"/> TEMPER TANTRUMS AND DISCIPLINE	<input type="checkbox"/> SAFETY
<input type="checkbox"/> COMMUNICATION AND SOCIAL DEVELOPMENT	• Distraction	• Car safety seat
• Give limited choices	• Praise	• Home safety
• Stranger anxiety	• Consistency	• Poisons
• Read and talk with child	<input type="checkbox"/> HEALTHY TEETH	• Falls
<input type="checkbox"/> SLEEP ROUTINES AND ISSUES	• First dentist visit	• Burns
• Consistent routines	• Healthy oral habits	• Smoke detectors
• Night waking	• No bottle	• Carbon monoxide detectors

Plan

Immunizations (See Vaccine Administration Record.)

Laboratory/Screening results _____

Referral to _____

Follow-up/Next visit _____

See other side

Print Name	Signature
PROVIDER 1	
PROVIDER 2	





Bright Futures Parent Handout

15 Month Visit

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

COMMUNICATION AND SOCIAL DEVELOPMENT

Talking and Feeling

- Show your child how to use words.
 - Use words to describe your child's feelings.
 - Describe your child's gestures with words.
 - Use simple, clear phrases to talk to your child.
 - When reading, use simple words to talk about the pictures.
- Try to give choices. Allow your child to choose between 2 good options, such as a banana or an apple, or 2 favorite books.
- Your child may be anxious around new people; this is normal. Be sure to comfort your child.

SLEEP ROUTINES AND ISSUES

A Good Night's Sleep

- Make the hour before bedtime loving and calm.
- Have a simple bedtime routine that includes a book.
- Put your child to bed at the same time every night. Early is better.
- Try to tuck in your child when she is drowsy but still awake.
- Avoid giving enjoyable attention if your child wakes during the night. Use words to reassure and give a blanket or toy to hold for comfort.

SAFETY

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.
- Follow the owner's manual to make the needed changes when switching the car safety seat to the forward-facing position.
- Never put your child's rear-facing seat in the front seat of a vehicle with a passenger airbag. The back seat is the safest place for children to ride
- Everyone should wear a seat belt in the car.
- Lock away poisons, medications, and lawn and cleaning supplies.
- Call Poison Help (1-800-222-1222) if you are worried your child has eaten something harmful.
- Place gates at the top and bottom of stairs and guards on windows on the second floor and higher. Keep furniture away from windows.
- Keep your child away from pot handles, small appliances, fireplaces, and space heaters.
- Lock away cigarettes, matches, lighters, and alcohol.
- Have working smoke and carbon monoxide alarms and an escape plan.
- Set your hot water heater temperature to lower than 120°F.

TEMPER TANTRUMS AND DISCIPLINE

Temper Tantrums and Discipline

- Use distraction to stop tantrums when you can.
- Limit the need to say "No!" by making your home and yard safe for play.
- Praise your child for behaving well.
- Set limits and use discipline to teach and protect your child, not punish.
- Be patient with messy eating and play. Your child is learning.
- Let your child choose between 2 good things for food, toys, drinks, or books.

HEALTHY TEETH

Healthy Teeth

- Take your child for a first dental visit if you have not done so.
- Brush your child's teeth twice each day after breakfast and before bed with a soft toothbrush and plain water.
- Wean from the bottle; give only water in the bottle.
- Brush your own teeth and avoid sharing cups and spoons with your child or cleaning a pacifier in your mouth.

What to Expect at Your Child's 18 Month Visit

We will talk about

- Talking and reading with your child
- Playgroups
- Preparing your other children for a new baby
- Spending time with your family and partner
- Car and home safety
- Toilet training
- Setting limits and using time-outs

Poison Help: 1-800-222-1222

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



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