### Bright Futures Previsit Questionnaire

**5 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.

<table>
<thead>
<tr>
<th>Category</th>
<th>Topics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ready for School</td>
<td>Your child's fears about school, After-school care, Talking with your child's teacher, Your child's friends, Bullying, Your child feeling sad</td>
</tr>
<tr>
<td>Your Child and Family</td>
<td>Family time together, Your child's chores, Your child handling his feelings, Your child being angry</td>
</tr>
<tr>
<td>Staying Healthy</td>
<td>Your child's weight, Eating fruits, Eating vegetables, Eating whole grains, Getting enough calcium, 1 hour of physical activity per day</td>
</tr>
<tr>
<td>Healthy Teeth</td>
<td>Regular dentist visits, Brushing teeth twice daily, Flossing daily</td>
</tr>
<tr>
<td>Safety</td>
<td>Street safety, Booster seats, Always wearing safety helmets, Swimming safety, Sunscreen, Preventing sexual abuse, Fire escape and fire drill plan, Carbon monoxide alarms in your home, Gun safety</td>
</tr>
</tbody>
</table>

#### 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

<table>
<thead>
<tr>
<th>Topic</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead</td>
<td>Does your child have a sibling or playmate who has or had lead poisoning?</td>
</tr>
<tr>
<td></td>
<td>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?</td>
</tr>
<tr>
<td></td>
<td>Does your child live in or regularly visit a house or child care facility built before 1950?</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>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)?</td>
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<tr>
<td></td>
<td>Has your child traveled (had contact with resident populations) for longer than 1 week to a country at high risk for tuberculosis?</td>
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<tr>
<td></td>
<td>Has a family member or contact had tuberculosis or a positive tuberculin skin test?</td>
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<tr>
<td></td>
<td>Is your child infected with HIV?</td>
</tr>
<tr>
<td>Anemia</td>
<td>Do you ever struggle to put food on the table?</td>
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<tr>
<td></td>
<td>Does your child's diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?</td>
</tr>
</tbody>
</table>

Does your child have any special health care needs?  

- [ ] No  
- [ ] Yes, describe:

<table>
<thead>
<tr>
<th>Have there been any major changes in your family lately?</th>
<th>Move, Job change, Separation, Divorce, Death in the family, Any other changes?</th>
</tr>
</thead>
</table>

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.

- [ ] Listens well and follows simple instructions
- [ ] Can tell a story with full sentences
- [ ] Counts to 10
- [ ] Names at least 4 colors
- [ ] Draws a person with 6 body parts
- [ ] Copies squares, triangles
- [ ] Writes some letters and numbers
- [ ] Balances on 1 foot
- [ ] Hops, skips, climbs
- [ ] Ties a knot

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Name

ID NUMBER

BIRTH DATE

WEIGHT (%)  HEIGHT (%)  BMI (%)  BLOOD PRESSURE

ACCOMPANIED BY/INFORMANT  PREFERRED LANGUAGE  DATE/TIME

Physical Examination

SEX

Light Futures Priority

- MOUTH/TEETH (caries, gingival)
- NEUROLOGIC (fine/gross motor)
- GAIT
- LANGUAGE

Additional Systems

- GENERAL APPEARANCE
- EYES
- EARS
- THROAT
- NOSE
- NECK
- LUNGS
- HEART
- ABDOMEN
- GENITALIA
- EXTREMITIES
- BACK
- SKIN

Abnormal findings and comments

Follow-up on previous concerns

Interval history

Medication Record reviewed and updated

Social/Family History

See Initial History Questionnaire.  No interval change

Family situation

After-school care:  Yes  No

Changes since last visit

Review of Systems

See Initial History Questionnaire and Problem List.

No interval change

Changes since last visit

Nutrition

Sleep:  NL

Physical activity

Play time (60 min/d)  Yes  No

Screen time (<2 h/d)  Yes  No

School:  Grade  Special education  Yes  No

Social interaction  NL

Performance  NL

Behavior  NL

Attention  NL

Homework  NL

Parent/Teacher concerns  None

Home:  Parent-child-sibling interaction  NL

Cooperation/Oppositional behavior  NL

Development (if not reviewed in Previsit Questionnaire)

- MOTOR
  - Balances on 1 foot
  - Hops and skips
  - Able to tie knot

- LANGUAGE
  - Good articulation/language skills
  - LEARNING
    - Draws person (6+ body parts)
    - Prints some letters and numbers
    - Copies squares, triangles

- Counts to 10
- Names 4 or more colors
- Follows simple directions
- Listens and attends

Immunizations (See Vaccine Administration Record.)

Laboratory/Screening results:

Vision  Hearing

Referral to

Follow-up/Next visit

Print Name

Signature

WELL CHILD/5 to 6 years
Healthy Teeth
• Help your child brush his teeth twice a day.
• After breakfast
• Before bed
• Use a pea-sized amount of toothpaste with fluoride.
• Help your child floss her teeth once a day.
• Your child should visit the dentist at least twice a year.

Ready for School
• Take your child to see the school and meet the teacher.
• Read books with your child about starting school.
• Talk to your child about school.
• Make sure your child is in a safe place after school with an adult.
• Talk with your child every day about things he liked, any worries, and if anyone is being mean to him.
• Talk to us about your concerns.

Your Child and Family
• Give your child chores to do and expect them to be done.
• Have family routines.
• Hug and praise your child.
• Teach your child what is right and what is wrong.
• Help your child to do things for herself.
• Children learn better from discipline than they do from punishment.
• Help your child deal with anger.
• Teach your child to walk away when angry or go somewhere else to play.

Staying Healthy
• Eat breakfast.
• Buy fat-free milk and low-fat dairy foods, and encourage 3 servings each day.
• Limit candy, soft drinks, and high-fat foods.
• Offer 5 servings of vegetables and fruits at meals and for snacks every day.
• Limit TV time to 2 hours a day.
• Do not have a TV in your child’s bedroom.
• Make sure your child is active for 1 hour or more daily.

Safety
• Your child should always ride in the back seat and use a car safety seat or booster seat.
• Teach your child to swim.
• Watch your child around water.
• Use sunscreen when outside.
• Provide a good-fitting helmet and safety gear for biking, skating, in-line skating, skiing, snowboarding, and horseback riding.
• Have a working smoke alarm on each floor of your house and a fire escape plan.
• Install a carbon monoxide detector in a hallway near every sleeping area.
• 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.
• Ask if there are guns in homes where your child plays. If so, make sure they are stored safely.
• Teach your child how to cross the street safely. Children are not ready to cross the street alone until age 10 or older.
• Teach your child about bus safety.
• Teach your child about how to be safe with other adults.
• No one should ask for a secret to be kept from parents.
• No one should ask to see private parts.
• No adult should ask for help with his private parts.

Poison Help: 1-800-222-1222
Child safety seat inspection:
1-866-SEATCHECK; seatcheck.org