



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.

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

Lead	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
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)?	<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
Anemia	Is your child infected with HIV?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Do you ever struggle to put food on the table?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Does your child's diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<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 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 tasks that your child is able to do.

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



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TO BE FILLED OUT BY PROVIDER

ACCOMPANIED BY/INFORMANT	PREFERRED LANGUAGE	DATE/TIME	
DRUG ALLERGIES		CURRENT MEDICATIONS	
WEIGHT (%) <small>See growth chart.</small>	HEIGHT (%)	BMI (%)	BLOOD PRESSURE

Name
ID NUMBER
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

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)

<input type="checkbox"/> MOTOR	<input type="checkbox"/> LANGUAGE	<input type="checkbox"/> Counts to 10
• Balances on 1 foot	• Good articulation/language skills	• Names 4 or more colors
• Hops and skips	<input type="checkbox"/> LEARNING	• Follows simple directions
• Able to tie knot	• Draws person (6+ body parts)	• Listens and attends
	• Prints some letters and numbers	
	• Copies squares, triangles	

Physical Examination

= NL

Bright Futures Priority

<input type="checkbox"/> EYES	<input type="checkbox"/> HEAD	<input type="checkbox"/> HEART
<input type="checkbox"/> MOUTH/TEETH (caries, gingival)	<input type="checkbox"/> EARS	<input type="checkbox"/> ABDOMEN
<input type="checkbox"/> NEUROLOGIC (fine/gross motor)	<input type="checkbox"/> THROAT	<input type="checkbox"/> GENITALIA
<input type="checkbox"/> GAIT	<input type="checkbox"/> NOSE	<input type="checkbox"/> EXTREMITIES
<input type="checkbox"/> LANGUAGE	<input type="checkbox"/> NECK	<input type="checkbox"/> BACK
	<input type="checkbox"/> LUNGS	<input type="checkbox"/> SKIN

Abnormal findings and comments

Assessment

Well child

Anticipatory Guidance

Discussed and/or handout given

<input type="checkbox"/> SCHOOL READINESS	<input type="checkbox"/> NUTRITION AND PHYSICAL ACTIVITY	<input type="checkbox"/> SAFETY
• Establish routines	• Healthy weight	• Sexual safety
• After-school care/activities	• Well-balanced diet, including breakfast	• Pedestrian safety
• Friends	• Fruits, vegetables, whole grains	• Safety helmets
• Bullying	• Adequate calcium	• Swimming safety
• Communicate with teachers	• 60 minutes of exercise/day	• Fire escape plan
• Family time	<input type="checkbox"/> ORAL HEALTH	• Smoke/carbon monoxide detectors
• Anger management	• Regular dentist visits	• Guns
• Discipline for teaching not punishment	• Brushing/Flossing	• Sun
• Limit TV	• Fluoride	• Appropriately restrained in all vehicles

Plan

Immunizations (See Vaccine Administration Record.)

Laboratory/Screening results: Vision Hearing

Referral to

Follow-up/Next visit

See other side

Print Name	Signature
PROVIDER 1	
PROVIDER 2	

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Bright Futures Parent Handout

5 and 6 Year Visits

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

ORAL HEALTH

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.

SCHOOL READINESS

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.

MENTAL HEALTH

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.

NUTRITION AND PHYSICAL ACTIVITY

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

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



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