# 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** | ☐ How to handle your upset child when you leave ☐ Handling your frustrations with your child ☐ Helping your child speak and learn ☐ Your child being scared of new people ☐ Knowing how to give your child limited choices |
| **A Good Night's Sleep** | ☐ Your child's bedtime routine ☐ Waking up at night |
| **Temper Tantrums and Discipline** | ☐ Temper tantrums ☐ How to discipline your child ☐ Encouraging good behavior |
| **Healthy Teeth** | ☐ Stop using the bottle/pacifier ☐ Brushing teeth ☐ First dentist visit ☐ Preventing tooth problems |
| **Safety** | ☐ Car safety seats ☐ Preventing fires, burns, and poisoning ☐ 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? | ☐ Yes | ☐ No | ☐ Unsure |
| | Do you have concerns about how your child speaks? | ☐ Yes | ☐ No | ☐ Unsure |
| **Vision** | Do you have concerns about how your child sees? | ☐ Yes | ☐ No | ☐ Unsure |
| | Have your child's eyes ever been injured? | ☐ Yes | ☐ No | ☐ Unsure |
| | Does your child hold objects close when trying to focus? | ☐ Yes | ☐ No | ☐ Unsure |
| | Do your child's eyes appear unusual or seem to cross, drift, or be lazy? | ☐ Yes | ☐ No | ☐ Unsure |
| | Do your child's eyelids droop or does one eyelid tend to close? | ☐ Yes | ☐ No | ☐ 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.**

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

List what words your child says.

Bright Futures™
prevention and health promotion for infants, children, adolescents, and their families™

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™