Bright Futures Parent Supplemental Questionnaire 2½ Year 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 circle Yes or No for each question. Thank you.

Family Routines

Do you and other family members set the same limits for your child?	Yes	No
Do you encourage family exercise such as walking, swimming, dancing, or bicycling?	Yes	No
Do you go to museums, zoos, and other educational places with your family?	Yes	No
Do you eat meals together as a family?	Yes	No
Do you have a regular bedtime routine for your child?	Yes	No
Does your child play actively for at least one hour per day?	Yes	No

Learning to Talk and Communicate: Language Promotion and Communication

Do you read to your child every day?	Yes	No
How many hours per day does your child watch TV?	_____ hours	
Do you use simple words when asking your child a question and give plenty of time for her to respond?	Yes	No
Do you listen when your child speaks and correct him?	Yes	No
Do you listen to your child carefully and simplify what she says?	Yes	No

Getting Along With Others: Promoting Social Development

Do you watch your child when he plays with other children?	Yes	No
Do you spend time alone with each of your children every day?	Yes	No
Does your child have daily routines for eating, sleeping, and playing?	Yes	No

Getting Ready for Preschool: Preschool Considerations

Do you have plans for child care or preschool in the next year?	Yes	No
Are you encouraging toilet training?	Yes	No
Is your child a part of a regular playgroup?	Yes	No
Do you read books to your child about getting ready for school?	Yes	No

Safety

Do you stay in arm's reach of your child when she is in or around water?		Yes	No
Do you empty buckets, tubs, or small pools right after using them?		Yes	No
Do you always use a car safety seat in the back seat of the car?		Yes	No
When your child plays outside, do you make sure that he stays within fences and gates?		Yes	No
Do you keep your child away from moving machines, lawn mowers, driveways, and streets?		Yes	No
Does your child always wear a helmet when she is riding a tricycle, in a motorized kid car, or in a seat on an adult's bicycle?		Yes	No
Do you have a swimming pool, pond, or lake in or near your home?		No	Yes
Do you always put sunscreen on your child before he goes outside?		Yes	No
Does anyone in your home or the homes where your child spends time have a gun?		No	Yes
If so, are the guns unloaded and locked away?	N/A	Yes	No
Does anyone smoke around your child?		No	Yes
If you smoke, would you like information on how to stop?		Yes	No
Are there working smoke and carbon monoxide detectors on every level of your home?		Yes	No
Have you taught your child how to safely approach pets?		Yes	No

Bright Futures Medical Screening Questionnaire
2½ Year Visit

Please answer the following questions about your child's health by circling Y, N, or Unsure.

Do you have concerns about how your child hears?	Y	N	Unsure
Do you have concerns about how your child speaks?	Y	N	Unsure
Do you have concerns about how your child sees?	Y	N	Unsure
Does your child hold objects close when trying to focus?	Y	N	Unsure
Do your child's eyes appear unusual or seem to cross, drift, or be lazy?	Y	N	Unsure
Do your child's eyelids droop or does one eyelid tend to close?	Y	N	Unsure
Have your child's eyes ever been injured?	Y	N	Unsure
Does your child have a dentist?	N	Y	Unsure
Does your child's primary water source contain fluoride?	N	Y	Unsure

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

American Academy of Pediatrics
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