Bright Futures Parent Supplemental Questionnaire 2 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.

Your Talking Child: Assessment of Language Development

Do you read with your child every day?	Yes	No
Do you use simple words when asking your child a question?	Yes	No
Do you give your child plenty of time to respond?	Yes	No
Can you understand what your child wants?	Yes	No
Does your child use 2-word sentences like “Go home”?	Yes	No
Do you have plans for child care or preschool in the next year?	Yes	No

How Your Child Behaves: Temperament and Behavior

Do you spend time alone with your child doing something that he likes to do?	Yes	No
Do you encourage other family members and caregivers to be consistent, patient, and calm with your child?	Yes	No
Does your child play with other children?	Yes	No

Toilet Training

Have you encouraged toilet training?	Yes	No
Does your child tell you when he has a bowel movement?	Yes	No
Is your child dry for about 2 hours at a time?	Yes	No
Does your child know the difference between wet and dry?	Yes	No
Is your child interested in using the toilet?	Yes	No
Do you help your child wash hands after going to the bathroom?	Yes	No
Have you taught your child to sneeze or cough into her shoulder?	Yes	No

Your Child and TV: Television Viewing

How many hours per day does your child watch TV?		_____ hours	
If your child watches TV, do you watch together and talk about what you are seeing?		Yes	No
Does your family enjoy being active together?		Yes	No
Does your child play actively for at least one hour per day?		Yes	No

Safety

Do you always use a car safety seat in the back seat of the car?		Yes	No
Do you watch your child when he plays outside?		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
Does anyone in your home or the homes where your child spends time have a gun?	N/A	Yes	No
If so, are the guns unloaded and locked away?		Yes	No
Does anyone smoke around your child?		No	Yes
If you smoke, would you like information on how to stop?		Yes	No

Bright Futures Medical Screening Questionnaire
2 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 sibling or playmate who has or had lead poisoning?	Y	N	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 last 6 months) renovated or remodeled?	Y	N	Unsure
Does your child live in or regularly visit a house or child care facility built before 1950?	Y	N	Unsure
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)?	Y	N	Unsure
Has your child traveled (had contact with resident populations) for longer than 1 week to a country at high risk for tuberculosis?	Y	N	Unsure
Has a family member or contact had tuberculosis or a positive tuberculin skin test?	Y	N	Unsure
Is your child infected with HIV?	Y	N	Unsure

Does your child have parents or grandparents who have had a stroke or heart problem before age 55?	Y	N	Unsure
Does your child have a parent with elevated blood cholesterol (240 mg/dL or higher) or who is taking cholesterol medication?	Y	N	Unsure
Do you ever struggle to put food on the table?	Y	N	Unsure
Does your child's diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?	N	Y	Unsure
Does your child have a dentist?	N	Y	Unsure
Does your child's primary water source contain fluoride?	N	Y	Unsure