Bright Futures Parent Supplemental Questionnaire 3 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 Support

Do your family members show love to one another?		Yes	No
Do you immediately stop your child from hitting or biting others?		Yes	No
Do you and other caregivers set the same limits for your child?		Yes	No
Do you allow your child to make choices like what clothes to wear or what books to read?		Yes	No
Do you spend time alone with each of your children?	N/A	Yes	No
Do you try to settle fights between your children without taking sides?	N/A	Yes	No
Do you take time for yourself?		Yes	No
Do you feel you are able to balance family and work?		Yes	No
Do you spend time alone with your partner?		Yes	No

Reading and Talking With Your Child: Encouraging Literacy Activities

Do you read, sing songs, or play word games with your child every day?	Yes	No
When you are reading together, do you ask your child questions about the pictures or story?	Yes	No
Do you ask your child to talk about her day?	Yes	No

Playing With Others: Playing With Peers

Does your child have chances to play with other children, like on playdates or at preschool?	Yes	No
When your child plays with other children, do you help him learn how to take turns?	Yes	No
Is your child in preschool or child care?	Yes	No
Do you have plans for child care or preschool in the next year?	Yes	No

Your Active Child: Promoting Physical Activity

Does your child watch TV more than 2 hours a day?	No	Yes
Are you physically active together as a family, like going on walks or playing in the park?	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 ever leave your child alone in the car, house, or yard?		No	Yes
Do you watch your child closely when she plays near streets or driveways?		Yes	No
Do you have furniture away from windows and window guards on all windows on the second floor or higher?		Yes	No
When your child plays outside, do you make sure that he stays within fences and gates?		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 with the ammunition locked seperately from the gun?	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

Bright Futures Medical Screening Questionnaire
3 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
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
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

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

American Academy of Pediatrics
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