Bright Futures Parent Supplemental Questionnaire 5 and 6 Year Visits

For us to provide 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.

Ready for School: School Readiness

Does your child go to school?	N/A	Yes	No
Do you know your child's teacher?		Yes	No
Are you able to attend your child's school functions?		Yes	No
Are you happy with your child's after-school care?		Yes	No
Do you have any concerns about your child doing well in school?		No	Yes
Do you know what signs to look for if your child is being bullied or teased?		Yes	No
Does your child receive any special education services?		No	Yes

Your Child and Family: Mental Health

Do you have special family activities, traditions, or routines?	Yes	No
Do you discipline your child to teach good behavior and not to punish?	Yes	No
Does your child do simple chores around the house?	Yes	No
Do you help your child control his anger?	Yes	No
Does your child fix problems with words and not violent behavior like biting or hitting?	Yes	No
Does your child get along with her friends?	Yes	No

Staying Healthy: Nutrition and Physical Activity

Does your child eat breakfast every day?	Yes	No
Does your child eat at least 5 servings of fruits and vegetables a day?	Yes	No
Does your child drink at least 3 servings of low-fat milk a day or eat yogurt or cheese?	Yes	No
Do you limit foods that are high in fat like candy, soft drinks, salty snacks, and fast food?	Yes	No
Do you have any concerns about your child's weight?	No	Yes
Is your child active at least 1 hour every day?	Yes	No
Does your child watch TV, play video games, or use the computer (not for schoolwork) for more than 2 hours a day?	No	Yes

Healthy Teeth: Oral Health

Does your child brush his teeth twice a day?	Yes	No
Does your child floss her teeth once a day?	Yes	No
Does your child see a dentist at least twice a year?	Yes	No

Safety

Do you always use a car safety seat or a booster seat in the back seat of all vehicles?		Yes	No
Does your child know street safety such as stopping at the curb, looking both ways, and never crossing the street without a grown-up?		Yes	No
Does your child always wear a helmet and other protective gear when biking, skating, horseback riding, skiing, or snowboarding?		Yes	No
Does your child know how to swim and only swim when an adult is watching?		Yes	No
Do you always put sunscreen on your child before he goes outside to play or swim?		Yes	No
Have you taught your child that it is never OK for an adult to tell a child to keep secrets from her parents?		Yes	No
Does your child know that is it never okay for an older child or adult to ask to see his private parts?		Yes	No
Does your family have and practice an escape plan in case a fire starts in your home?		Yes	No
Are there smoke and carbon monoxide detectors on every floor of your house?		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 separately 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
6 Year Visit

Please answer the following questions about your child's health by circling Y, N, or 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
Does your child eat a strict vegetarian diet?	Y	N	Unsure
If your child is a vegetarian, does your child take an iron supplement?	N	Y	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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