Bright Futures Previsit Questionnaire
8 Year Visit

For us to provide 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.

School	☐ How your child is learning and doing in school ☐ Bullying ☐ After-school activities and care ☐ Special education needs ☐ How your child acts ☐ Talking with your child's school
Your Growing Child	☐ How your child feels about herself ☐ Following rules ☐ Getting ready for puberty ☐ Being angry ☐ Your child dealing with his problems ☐ Becoming more independent
Staying Healthy	☐ Your child's weight ☐ 1 hour of physical activity daily ☐ Playing sports ☐ TV time ☐ Getting enough calcium ☐ Drinking enough water ☐ How much your child should eat at one time
Healthy Teeth	☐ Regular dentist visits ☐ Brushing teeth twice daily ☐ Flossing daily
Safety	☐ Booster seats ☐ Helmets and sports safety ☐ Swimming safety ☐ Wearing sunscreen ☐ Knowing your child's computer use ☐ Knowing your child's friends and their families ☐ Gun safety ☐ Smoke-free house and cars ☐ Preventing sexual abuse

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

Tuberculosis	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)?	☐ Yes	☐ No	☐ Unsure
	Has your child traveled (had contact with resident populations) for longer than 1 week to a country at high risk for tuberculosis?	☐ Yes	☐ No	☐ Unsure
	Has a family member or contact had tuberculosis or a positive tuberculin skin test?	☐ Yes	☐ No	☐ Unsure
	Is your child infected with HIV?	☐ Yes	☐ No	☐ Unsure
Dyslipidemia	Does your child have parents or grandparents who have had a stroke or heart problem before age 55?	☐ Yes	☐ No	☐ Unsure
	Does your child have a parent with elevated blood cholesterol (240 mg/dL or higher) or who is taking cholesterol medication?	☐ Yes	☐ No	☐ Unsure
Anemia	Does your child eat a strict vegetarian diet?	☐ Yes	☐ No	☐ Unsure
	If your child is a vegetarian, does your child take an iron supplement?	☐ No	☐ Yes	☐ Unsure
	Does your child's diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?	☐ No	☐ Yes	☐ 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 changes?

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 concerns about your child's development, learning, or behavior? ☐ No ☐ Yes, describe:

Check off each of the following that are true for your child.

- ☐ Eats healthy meals and snacks
- ☐ Has friends
- ☐ Is doing well in school
- ☐ Participates in an after-school activity
- ☐ Is vigorously active for 1 hour a day
- ☐ Does chores when asked
- ☐ Gets along with friends

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

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