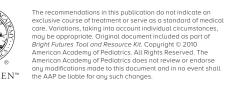


Bright Futures Previsit Questionnaire 10 **Year Visit**

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	s, or problems that you would like to discuss today?						
We are intereste	d in answering your	questions. Please check off the boxes for the topics you would like to discuss the	most toda	ıy.				
School		☐ How your child is doing in school ☐ Homework ☐ Bullying						
Your Growing Child		☐ How your child feels about herself ☐ Dealing with your child's anger ☐ Setting limits for your child ☐ Your child's friends ☐ Readiness for middle school ☐ Your child's sexuality ☐ Puberty						
Staying Healthy		☐ Your child's weight ☐ Your child's body image ☐ Eating breakfast ☐ Limiting soft drinks ☐ Eating together as a family ☐ Drinking enough water ☐ Limiting high-fat food ☐ 1 hour of physical activity daily						
Healthy Teeth		☐ Regular dentist visits ☐ Brushing teeth twice daily ☐ Flossing daily						
Safety		☐ Bicycle and sports safety and helmets ☐ Car safety ☐ Swimming safety ☐ Sunscreen ☐ Knowing your child's friends and their families ☐ Preventing cigarette, alcohol, and drug use ☐ Gun safety						
		Questions About Your Child						
Have any of your	child's relatives de	veloped new medical problems since your last visit? If yes, please describe:	☐ Yes	□ No	☐ Unsure			
Tuberculosis		n in a country at high risk for tuberculosis (countries other than the United States, New Zealand, or Western Europe)?	☐ Yes	□ No	☐ Unsure			
	Has your child trav at high risk for tube	eled (had contact with resident populations) for longer than 1 week to a country erculosis?	☐ Yes	□ No	☐ Unsure			
		per or contact had tuberculosis or a positive tuberculin skin test?	☐ Yes	☐ No	☐ Unsure			
	Is your child infecte	ed with HIV?	☐ Yes	☐ No	☐ Unsure			
Dyslipidemia		ve 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?			□ No	☐ Unsure			
		a strict vegetarian diet?	☐ Yes	☐ No	☐ Unsure			
Anemia		getarian, 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?			☐ 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 I	ive with anyone wh	o uses tobacco or spend time in any place where people smoke? $\ \square$ No $\ \square$ Yes						
		Your Growing and Developing Child						
Do you have spe	cific concerns abou	your child's development, learning, or behavior? \square No \square Yes, describe:						
□ Ea □ Ha □ Is □ Fe	of the following that ats healthy meals and as friends doing well in school eels good about himse ets along with family	☐ Vigorously exercises for 1 hour a day ☐ Does chores when asked	describe: _					







Futures. Bright Futures Parent Supplemental Questionnaire 9 and 10 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 guestion. Thank you.

School		
Do you show interest in your child's school and after-school activities?	Yes	No
Do you set routines for your child's homework and create a quiet environment to do homework?	Yes	No
Do you know what signs to look for if your child is being bullied or teased?	Yes	No
Your Growing Child: Development and Mental Health		
Does your child do simple chores around the house?	Yes	No
Do you encourage your child to make good decisions?	Yes	No
Is your child a happy person?	Yes	No
Has you child been having any recent problems in school or at home?	No	Yes
Do you teach your child that it is not OK to use alcohol, cigarettes, and drugs?	Yes	No
Do you answer your child's questions about sex?	Yes	No
Do you teach your child that it is important to wait to have sex?	Yes	No
Does your child know 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 OK for an older child or adult to ask to see his private parts?	Yes	No
Do you feel comfortable talking to and answering your child's questions about her changing body?	Yes	No
Staying Healthy: Nutrition and Physical Activity		
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
Does your child regularly eat breakfast?	Yes	No
Do you limit foods that are high in fat, like candy, soft drinks, salty snacks, or fast food?	Yes	No
Do you eat meals together as a family at least once a week?	Yes	No

 $continued\ on\ page\ 2$

Staying Healthy: Nutrition and Physical Activity cor	ntinued from page	1	
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) 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 once a day?	Yes	No	
Does your child visit the dentist twice a year?	Yes	No	
If your child is playing sports, does she always wear a mouth guard to protect teeth?	Yes	No	
Safety			
Does anyone smoke around your child?		No	Yes
If you smoke, would you like information on how to stop?	Yes	No	
Do you tell your child that using drugs is bad?	Yes	No	
Does your child know how to get help in an emergency when you are not there?	Yes	No	
Does everyone in the family use a seat belt?	Yes	No	
Does your child sit in the back seat every time he rides in the car in a booster seat with the seat belt on?	Yes	No	
Does your child always wear a helmet and other protective gear when biking, skating, or skiing?	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 she goes outside to play or swim?	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?	Yes	No	
Do you know your child's friends and their families?			No



American Academy of Pediatrics



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