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, 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 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 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 specific 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
☐ Feels good about himself
☐ Gets along with family
☐ Participates in an after-school activity
☐ Vigorously exercises for 1 hour a day
☐ Does chores when asked
☐ Getting chances to make own decisions
☐ Does an activity really well; describe: _____

_____

_____

_____

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

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

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate. Original document included as part of *Bright Futures Tool and Resource Kit.* Copyright © 2010 American Academy of Pediatrics. All Rights Reserved. The American Academy of Pediatrics does not review or endorse any modifications made to this document and in no event shall the AAP be liable for any such changes.

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 question. 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 *continued 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?	N/A	Yes	No
Do you know your child's friends and their families?		Yes	No

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate. Original document included as part of *Bright Futures Tool and Resource Kit.* Copyright © 2010 American Academy of Pediatrics. All Rights Reserved. The American Academy of Pediatrics does not review or endorse any modifications made to this document and in no event shall the AAP be liable for any such changes.