

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	y concerns, questions	s, or problems that yo	u would like to o	liscuss today?				
We are intereste	ed in answering your	questions. Please ch	eck off the boxe	s for the topics yo	u would like to discu	ss the most toda	ay.	
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 Teoth		☐ 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 A	bout Your C	hild	1111	1.1	
Have any of you	r child's relatives dev	veloped 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
Dysilpidemia	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 hea	ith care needs?	iNo □ Yes, de	scribe:				
Have there beer	any major changes	in your family lately?	☐ Move ☐ Joi	change 🗅 Sepa	ration Divorce 🗆	Death in the fam	nily □ An	y other changes?
Does your child	live with anyone who	uses tobacco or spe	nd time in any p	lace where peopl	e smoke? 🗆 No 🏻	⊒ Yes		
		Your	Growing an	d Developin	g Child			
Do you have cor	ncerns about your chi	lid's development, lea	ırning, or behavid	or? 🗆 No 🗅	Yes, describe:			
Check off each	of the following that a	are true for your child						
☐ Eats healthy meals and snacks ☐ Participates in an after-school activity ☐ Does chores when asked ☐ Has friends ☐ Is vigorously active for 1 hour a day ☐ Gets along with friends								



American Academy of Pediatrics



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