



# Bright Futures Previsit Questionnaire 4 Year Visit

For us to provide you and 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.

<b>Getting Ready for School</b>	<input type="checkbox"/> How your child is doing in preschool	<input type="checkbox"/> How your child does playing with other children
<b>Healthy Habits</b>	<input type="checkbox"/> If your child is ready for grade school	<input type="checkbox"/> How your child is speaking
<b>TV and Media</b>	<input type="checkbox"/> How much TV is too much TV	<input type="checkbox"/> Encouraging your child to be active
<b>Your Community</b>	<input type="checkbox"/> Your child's feelings	<input type="checkbox"/> Your child's weight
<b>Safety</b>	<input type="checkbox"/> Fun activities to do outside the home	<input type="checkbox"/> Educational programs in the community
	<input type="checkbox"/> Getting along with other children and adults	<input type="checkbox"/> Feeling safe in your home
	<input type="checkbox"/> Answering questions about your child's body	<input type="checkbox"/> Playing safely with other children
	<input type="checkbox"/> Car safety seats and booster seats	<input type="checkbox"/> Being safe outside
	<input type="checkbox"/> Gun safety	<input type="checkbox"/> Keeping your child safe from 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

<b>Lead</b>	Does your child have a sibling or playmate who has or had lead poisoning?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> 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 past 6 months) renovated or remodeled?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Does your child live in or regularly visit a house or child care facility built before 1950?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
<b>Tuberculosis</b>	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)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Has your child traveled (had contact with resident populations) for longer than 1 week to a country at high risk for tuberculosis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Has a family member or contact had tuberculosis or a positive tuberculin skin test?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
<b>Dyslipidemia</b>	Is your child infected with HIV?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Does your child have parents or grandparents who have had a stroke or heart problem before age 55?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Does your child have a parent with elevated blood cholesterol (240 mg/dL or higher) or who is taking cholesterol medication?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
<b>Anemia</b>	Do you ever struggle to put food on the table?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Does your child's diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unsure

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:

Does your child have any special health care needs?  No  Yes, describe:

Check off each of the tasks that your child is able to do.

- Builds a tower of 8 small blocks
- Copies a cross
- Can balance on each foot
- Names 4 colors
- Hops on 1 foot
- Draws a person with 3 parts
- Dresses herself, including buttons
- Plays pretend by himself and with others
- Knows her name, age, and whether she is a boy or girl
- Plays board or card games
- Other people can understand what he is saying
- Brushes own teeth



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ACCOMPANIED BY/INFORMANT	PREFERRED LANGUAGE	DATE/TIME
DRUG ALLERGIES	CURRENT MEDICATIONS	
WEIGHT (%) <small>See growth chart.</small>	HEIGHT (%)	BMI (%)
		BLOOD PRESSURE

Name
ID NUMBER
TEMPERATURE
BIRTH DATE
AGE
M F

### History

<input type="checkbox"/> Previsit Questionnaire reviewed	<input type="checkbox"/> Child has special health care needs
<input type="checkbox"/> Child has a dental home	

Concerns and questions  None  Addressed (see other side)

Follow-up on previous concerns  None  Addressed (see other side)

Interval history  None  Addressed (see other side)

Medication Record reviewed and updated

### Physical Examination

= NL

**Bright Futures Priority**

<input type="checkbox"/> <b>NEUROLOGIC</b>	<input type="checkbox"/> <b>Additional Systems</b>	<input type="checkbox"/> LUNGS
<input type="checkbox"/> FINE MOTOR SKILLS	<input type="checkbox"/> GENERAL APPEARANCE	<input type="checkbox"/> HEART
<input type="checkbox"/> GROSS MOTOR SKILLS	<input type="checkbox"/> HEAD	<input type="checkbox"/> ABDOMEN
<input type="checkbox"/> LANGUAGE	<input type="checkbox"/> EARS	<input type="checkbox"/> GENITALIA
<input type="checkbox"/> SPEECH	<input type="checkbox"/> NOSE	<input type="checkbox"/> EXTREMITIES
<input type="checkbox"/> THOUGHT PROCESS	<input type="checkbox"/> MOUTH AND THROAT	<input type="checkbox"/> BACK
<input type="checkbox"/> TEETH (caries, white spots, staining)	<input type="checkbox"/> NECK	<input type="checkbox"/> SKIN

Abnormal findings and comments \_\_\_\_\_

### Social/Family History

See Initial History Questionnaire.  No interval change

**Family situation**

Parents working outside home:  Mother  Father

Child care:  Yes  No Type \_\_\_\_\_

Preschool:  Yes  No \_\_\_\_\_

Changes since last visit \_\_\_\_\_

### Assessment

Well child

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Review of Systems

See Initial History Questionnaire and Problem List.

No interval change

Changes since last visit \_\_\_\_\_

Nutrition \_\_\_\_\_

Elimination:  NL \_\_\_\_\_

Toilet trained:  Yes  No \_\_\_\_\_

Sleep:  NL \_\_\_\_\_

Behavior/Temperament:  NL \_\_\_\_\_

Physical activity

Play time (60 min/d)  Yes  No

Screen time (<2 h/d)  Yes  No

Toxic exposure: Passive smoking  Yes  No

Parent-child interaction

Communication:  NL \_\_\_\_\_

Choices:  NL \_\_\_\_\_

Cooperation:  NL \_\_\_\_\_

Appropriate responses to behavior:  NL \_\_\_\_\_

### Anticipatory Guidance

Discussed and/or handout given

<input type="checkbox"/> <b>SCHOOL READINESS</b>	<input type="checkbox"/> <b>TV/MEDIA</b>	<input type="checkbox"/> <b>SAFETY</b>
• Model behavior	• Limit TV/video to 1–2 hours/day	• Appropriately restrained in all vehicles
• Be sensitive to child's feelings	• No TV in bedroom	• Supervise all outdoor play
• Encourage play with other children	<input type="checkbox"/> <b>CHILD AND FAMILY INVOLVEMENT</b>	• Guns
• Consider preschool	• Community activities	
• Daily reading	• Expect curiosity about body—answer questions using proper terms	
• Talk with child	<input type="checkbox"/> <b>HEALTHY PERSONAL HABITS</b>	
<input type="checkbox"/> <b>HEALTHY PERSONAL HABITS</b>	• Safety rules with adults	
• Calm bedtime routine	• Good and bad touches	
• Brush teeth twice daily	• How to seek help when needed	
• Daily physical activity		

### Development (if not reviewed in Previsit Questionnaire)

<input type="checkbox"/> <b>SOCIAL-EMOTIONAL</b>	<input type="checkbox"/> <b>COGNITIVE</b>	<input type="checkbox"/> <b>PHYSICAL DEVELOPMENT</b>
• Interactions with peers	• Names 4 colors	• Hops on 1 foot
• Fantasy play	• Draws person (3 body parts)	• Balances on 1 foot for 2 seconds
<input type="checkbox"/> <b>COMMUNICATIVE</b>	• Plays board/card games	• Builds tower (8 blocks)
• Usually understandable		• Copies a cross
• Knows name, age, gender		• Brushes own teeth
		• Dresses self

### Plan

Immunizations (See Vaccine Administration Record.)

Laboratory/Screening results:  Vision  Hearing

Referral to \_\_\_\_\_

**Follow-up/Next visit** \_\_\_\_\_

See other side

Print Name	Signature
PROVIDER 1	
PROVIDER 2	



**This American Academy of Pediatrics Visit Documentation Form is consistent with  
*Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, 3rd Edition.***

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# Bright Futures Parent Handout 4 Year Visit

Here are some suggestions from Bright Futures experts that may be of value to your family.

## Getting Ready for School

- Ask your child to tell you about her day, friends, and activities.
- Read books together each day and ask your child questions about the stories.
- Take your child to the library and let her choose books.
- Give your child plenty of time to finish sentences.
- Listen to and treat your child with respect. Insist that others do so as well.
- Model apologizing and help your child to do so after hurting someone's feelings.
- Praise your child for being kind to others.
- Help your child express her feelings.
- Give your child the chance to play with others often.
- Consider enrolling your child in a preschool, Head Start, or community program. Let us know if we can help.

DEVELOPING HEALTHY PERSONAL HABITS

## Healthy Habits

- Have relaxed family meals without TV.
- Create a calm bedtime routine.
- Have the child brush his teeth twice each day using a pea-sized amount of toothpaste with fluoride.
- Have your child spit out toothpaste, but do not rinse his mouth with water.

## Safety

- Use a forward-facing car safety seat or booster seat in the back seat of all vehicles.
- Switch to a belt-positioning booster seat when your child reaches the weight or height limit for her car safety seat, her shoulders are above the top harness slots, or her ears come to the top of the car safety seat.
- Never leave your child alone in the car, house, or yard.
- Do not permit your child to cross the street alone.
- Never have a gun in the home. If you must have a gun, store it unloaded and locked with the ammunition locked separately from the gun. Ask if there are guns in homes where your child plays. If so, make sure they are stored safely.
- Supervise play near streets and driveways.

SAFETY

## Your Community

- Stay involved in your community. Join activities when you can.
- Use correct terms for all body parts as your child becomes interested in how boys and girls differ.
- Teach your child about how to be safe with other adults.
  - No one should ask for a secret to be kept from parents.
  - No one should ask to see private parts.
  - No adult should ask for help with his private parts.
- Know that help is available if you don't feel safe.

TELEVISION AND MEDIA

## TV and Media

- Be active together as a family often.
- Limit TV time to no more than 2 hours per day.
- Discuss the TV programs you watch together as a family.
- No TV in the bedroom.
- Create opportunities for daily play.
- Praise your child for being active.

## What to Expect at Your Child's 5 and 6 Year Visits

### We will talk about

- Keeping your child's teeth healthy
- Preparing for school
- Dealing with child's temper problems
- Eating healthy foods and staying active
- Safety outside and inside

Poison Help: 1-800-222-1222

Child safety seat inspection:  
1-866-SEATCHECK; seatcheck.org

SCHOOL READINESS

CHILD AND FAMILY INVOLVEMENT AND SAFETY IN THE COMMUNITY



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