PATIENT NAME: _____ **DATE:** _____

Please print.

American Academy of Pediatrics

BRIGHT FUTURES PREVISIT QUESTIONNAIRE
10 YEAR VISIT

To provide you and your child with the best possible health care, we would like to know how things are going. Please answer all 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? ○ **No** ○ **Yes,** describe:

TELL US ABOUT YOUR CHILD AND FAMILY.

What excites or delights you most about your child?

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

Have there been major changes lately in your child's or family's life? ○ **No** ○ **Yes,** describe:

Have any of your child's relatives developed new medical problems since your last visit? ○ **No** ○ **Yes** ○ **Unsure** If yes or unsure, please describe:

Does your child live with anyone who smokes or spend time in places where people smoke or use e-cigarettes? ○ **No** ○ **Yes** ○ **Unsure**

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 items that are true for your child.

☐ Shows the ability to get along with others and control his emotions
☐ Chooses to eat healthy foods and participate in physical activity every day
☐ Forms caring, supportive relationships with family members, other adults, and peers

PATIENT NAME: _____ **DATE:** _____

Please print.

10 YEAR VISIT

RISK ASSESSMENT

Anemia	Does your child's diet include iron-rich foods, such as meat, iron-fortified cereals, or beans?	O Yes	O No	O Unsure
	Does your child eat a vegetarian diet (does not eat red meat, chicken, fish, or seafood)?	O No	O Yes	O Unsure
	If your child is a vegetarian (does not eat red meat, chicken, fish, or seafood), does your child take an iron supplement?	O Yes	O No	O Unsure
	Do you ever struggle to put food on the table?	O No	O Yes	O Unsure
Oral health	Does your child's primary water source contain fluoride?	O Yes	O No	O Unsure
Tuberculosis	Was your child or any household member born in, or has he or she traveled to, a country where tuberculosis is common (this includes countries in Africa, Asia, Latin America, and Eastern Europe)?	O No	O Yes	O Unsure
	Has your child had close contact with a person who has tuberculosis disease or who has had a positive tuberculosis test result?	O No	O Yes	O Unsure
	Is your child infected with HIV?	O No	O Yes	O Unsure

ANTICIPATORY GUIDANCE

How are things going for you, your child, and your family?

YOUR FAMILY'S HEALTH AND WELL-BEING

Neighborhood and Family Violence		
Are there frequent reports of violence in your community or school?	O No	O Yes
Has your child ever been bullied or hurt physically by someone?	O No	O Yes
Has your child felt excluded or not a part of any group of friends?	O No	O Yes
Has your child ever told you she was touched in a way that made her uncomfortable or on her private parts?	O No	O Yes
Food Security		
Within the past 12 months, were you ever worried whether your food would run out before you got money to buy more?	O No	O Yes
Within the past 12 months, did the food you bought not last, and you did not have money to get more?	O No	O Yes
Tobacco, E-cigarettes, Alcohol, and Drugs		
Is there anyone in your child's life whose alcohol or drug use concerns you?	O No	O Yes
Do any of your child's friends smoke, use or vape e-cigarettes, drink alcohol or beer, or use drugs?	O No	O Yes
Harm From the Internet		
Do you know about your child's Internet use?	O Yes	O No
Do you have rules for the Internet?	O Yes	O No
Have you installed an Internet safety filter on computers, tablets, and smartphones?	O Yes	O No
Emotional Security and Self-esteem		
Does your child usually seem happy?	O Yes	O No
Are there things your child is really good at doing or is proud of?	O Yes	O No
Does your child have the chance to help others at home, at school, or in your community?	O Yes	O No
Connectedness With Family and Peers		
Do your family members get along well with each other?	O Yes	O No
Does your family do things together?	O Yes	O No
Does your child have chores or responsibilities at home?	O Yes	O No
Does your child have friends at school or in your neighborhood?	O Yes	O No

PATIENT NAME: _____ **DATE:** _____

Please print.

10 YEAR VISIT

YOUR GROWING CHILD

Temper Problems, Setting Reasonable Limits, and Friends		
Has your child experienced any recent stresses at home or in school?	○ No	○ Yes
Do you have clear rules and expectations for your child?	○ Yes	○ No
When your child breaks the rules, are you consistent with consequences and discipline?	○ Yes	○ No
Do you help your child control his anger, deal with worries, and solve problems?	○ Yes	○ No
Have you and your child talked about how to say no to smoking, alcohol, and drug use?	○ Yes	○ No
Onset of Puberty and Sexual Safety		
Have you talked with your child about the body changes that occur during puberty?	○ Yes	○ No
Have you discussed privacy and body safety with your child?	○ Yes	○ No
Have you and your child talked about sex?	○ Yes	○ No
Does your child know to tell a trusted adult if someone touches her private parts or if someone encourages her to do other things that make her uncomfortable or she knows are wrong?	○ Yes	○ No

SCHOOL

Do you have concerns about your child's school experience?	○ No	○ Yes
Has your child missed more than 2 days of school in any month?	○ No	○ Yes
Does your child have any difficulties at school or get extra help in any subjects?	○ No	○ Yes
Does your child participate in activities outside of school?	○ Yes	○ No

STAYING HEALTHY

Healthy Teeth		
Does your child have a dentist?	○ Yes	○ No
Does your child brush and floss his teeth every day?	○ Yes	○ No
Does your child use a mouth guard when playing contact sports?	○ Yes	○ No
Does your child regularly drink soda, juice, or other sugar-sweetened drinks?	○ No	○ Yes
Nutrition		
Do you have any concerns about your child's weight?	○ No	○ Yes
Do you have any concerns about her eating? This includes drinking enough milk and eating vegetables and fruits.	○ No	○ Yes
Do you eat family meals together?	○ Yes	○ No
Do you hear your child talking about how he looks or dieting?	○ No	○ Yes
Physical Activity		
Is your child physically active at least 1 hour a day? This includes running, playing sports, or active play with friends.	○ Yes	○ No
Do you have any concerns about your child's physical activity level, such as it being either too much or too little?	○ No	○ Yes
Does your child have trouble going to sleep or does she wake up during the night?	○ No	○ Yes
How much time every day does your child spend watching TV, playing video games, or using computers, tablets, or smartphones (not counting schoolwork)?	_____ hours	
Does your child have a TV or an Internet-connected device in his bedroom?	○ No	○ Yes
Has your family made a family media use plan to help everyone balance time spent on media with other family and personal activities?	○ Yes	○ No

SAFETY

Car Safety		
Does your child always sit in a belt-positioning booster seat or lap and shoulder seat belt in the back seat every time she rides in a vehicle?	○ Yes	○ No
Does everyone in the vehicle always use a lap and shoulder seat belt?	○ Yes	○ No
Safety During Physical Activity		
Does your child always wear a helmet to protect his head when biking, skating, or doing other outdoor activities?	○ Yes	○ No

PATIENT NAME: _____ **DATE:** _____

Please print.

10 YEAR VISIT

SAFETY (*CONTINUED*)

Outdoor Safety		
Does your child know how to swim?	○ Yes	○ No
Does your child know to always have an adult watching her in the water and never to swim alone?	○ Yes	○ No
Does your child always use sunscreen when playing outside?	○ Yes	○ No
Knowing Your Child's Friends and Their Families		
Do you know your child's friends and their families?	○ Yes	○ No
Does your child know how to get help in an emergency if you are not there?	○ Yes	○ No
Gun Safety		
Does anyone in your home or the homes where your child spends time have a gun?	○ No	○ Yes
If yes, is the gun unloaded and locked up?	○ Yes	○ No
If yes, is the ammunition stored and locked up separately from the gun?	○ Yes	○ No
Have you talked with your child about gun safety?	○ Yes	○ No

Consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents,* 4th Edition

For more information, go to https://brightfutures.aap.org.

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Well Child | 9 and 10 Year Visits

Accompanied By:	Preferred Language:	Date/Time:	**Name:**
Weight (%):	Height (%):	BMI (%):	BP (%):	ID Number:
Vitals (*if indicated*): Temp:	HR:	Resp Rate:	SpO_2:	Birth Date:	Age:	Sex: M F

HISTORY

Concerns and Questions: ☐ None

Interval History: ☐ None

Medical History: ☐ Child has special health care needs.

Areas reviewed and updated as needed

☐ Past Medical History (See Initial History Questionnaire.)

☐ Surgical History (See Initial History Questionnaire.)

☐ Problem List (See Problem List.)

Medications: ☐ None

☐ Reviewed and updated (See Medication Record.)

Allergies: ☐ No known drug allergies

Nutrition: ☐ Good appetite ☐ Good variety

☐ Daily fruits and vegetables: _____

☐ Iron: Source: _____

☐ Calcium: Source: _____ Amount: _____

Comments:

Girls: Menarche: ☐ No ☐ Yes: _____

Dental Home: ☐ No ☐ Yes: _____

Brushing twice daily: ☐ Yes ☐ No: _____

Fluoride: ☐ In water source ☐ Oral supplement ☐ Other: _____

Sugar-sweetened beverages: ☐ No ☐ Yes

Elimination: ☐ Regular soft stools: _____

Sleep: ☐ No concerns

Physical Activity:

Exercise (60 min/d): ☐ Yes ☐ No: _____

Screen time: h/d: _____

Source: _____

Family media use plan discussed: ☐ Yes ☐ No

School: Grade: _____ IEP/504/behavior plan: ☐ Yes ☐ No ☐ NA

Performance: ☐ NL _____

Parent/teacher concerns: ☐ None

Behavior: ☐ No concerns

Parent-child-sibling interaction: ☐ NL _____

Cooperation: ☐ Yes ☐ No Oppositional behavior: ☐ Yes ☐ No

DEVELOPMENT

☑ = Normal development ☐ See Previsit Questionnaire.

Caregiver concerns about development: ☐ None ☐ Yes: _____

☐ Shows the ability to get along with others and control emotions

☐ Chooses to eat healthy foods and participate in physical activity every day

☐ Forms caring, supportive relationships with family members, other adults, and peers

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Name: _____

SOCIAL AND FAMILY HISTORY

Areas reviewed and updated as needed (See Initial History Questionnaire.): ☐ Social History ☐ Family History

Changes since last visit: _____ ☐ No interval change

Smoking household: ☐ No ☐ Yes: _____ Firearms in home: ☐ No ☐ Yes: _____

Observation of parent-child interaction: _____

Parents working outside home: ☐ One parent ☐ Both parents After-school care: _____

REVIEW OF SYSTEMS

☐ A 10-point review of systems was performed and results were negative except for any positive results listed below.
Bold = Focus area for this Bright Futures Visit

Constitutional: _____ **Respiratory:** _____ **Skin:** _____

Eyes: _____ **Gastrointestinal:** _____ **Neurological:** _____

Head, Ears, Nose, and Throat: _____ Genitourinary: _____ Other: _____

Cardiovascular: _____ **Musculoskeletal:** _____ Other: _____

PHYSICAL EXAMINATION

☑ = System examined **Bold** = Focus area for this Bright Futures Visit
Normal examination findings in text. Cross out abnormalities. Describe other findings in the area provided.

☐ **General:** Well-appearing child. **Normal BMI and BP for age.** _____

☐ Head: Normocephalic and atraumatic. _____

☐ Eyes: Pupils equal, round, and reactive to light. Extraocular eye movements intact. Normal funduscopic examination findings. _____

☐ Ears, nose, **mouth,** and throat: Tympanic membranes with visible light reflex bilaterally. Healthy-appearing teeth without visible caries.

☐ Neck: Supple, with full range of motion and no significant adenopathy. _____

☐ Heart: Regular rate and rhythm. No murmur. _____

☐ Respiratory: Breath sounds clear bilaterally. Comfortable work of breathing. _____

☐ Abdomen: Soft, with no palpable masses. _____

☐ Genitourinary:

- ☐ Normal female external genitalia. _____
- ☐ Normal male external genitalia. _____

Sexual Maturity Rating

- ☐ **Female: Breast development SMR** _____, **pubic hair SMR** _____
- ☐ **Male: Testicular development SMR** _____, **pubic hair SMR** _____

☐ Musculoskeletal: Spine straight. Full range of motion in hips, knees, and ankles. _____

☐ Neurological: Normal gait. Normal strength and tone. _____

☐ **Skin:** Warm and well perfused. No rashes or bruising. **No signs of cutting or other self-injury.** _____

Other comments: _____

ASSESSMENT

☐ Well child ☐ Normal interval growth (See growth chart.) ☐ Normal BMI percentile for age ☐ Normal BP percentile for age

Name: _____

ANTICIPATORY GUIDANCE

☑ Discussed and/or handout given

☐ **SOCIAL DETERMINANTS OF HEALTH**
- Neighborhood and family violence
- Food security
- Family substance use
- Harm from the Internet
- Emotional security and self-esteem
- Connectedness with family and peers

☐ **DEVELOPMENT AND MENTAL HEALTH**
- Temper problems, setting reasonable limits, and friends
- Sexuality

☐ **SCHOOL**
- School attendance
- School problems
- School performance and progress
- Transitions
- Co-occurrence of middle school and pubertal transitions

☐ **PHYSICAL GROWTH AND DEVELOPMENT**
- Oral health
- Nutrition
- Physical activity

☐ **SAFETY**
- Car safety
- Safety during physical activity
- Water safety
- Sun protection
- Knowing child's friends and their families
- Gun safety

PLAN

Immunizations: ☐ Vaccine Administration Record reviewed Administered today: _____ ☐ Up-to-date for age

Universal Screening:

☐ Dyslipidemia (once between 9 y and 11 y): Completed age: _____ Result: ☐ Within reference range ☐ Abnormal: _____

☐ Hearing (age 10 y): Result: ☐ Normal hearing BL ☐ Abnormal: _____

☐ Vision (age 10 y): Result: ☐ Normal vision for age ☐ Abnormal: _____

Selective Screening (based on risk assessment) (See Previsit Questionnaire.):

☐ Anemia ☐ Hearing (age 9 y) ☐ Oral health ☐ Tuberculosis ☐ Vision (age 9 y)

Comments/results:

Follow-up:

☐ Routine follow-up in 1 year ☐ Next visit: _____ ☐ Referral to: _____

PRINT NAME.	SIGNATURE
Provider 1	
Provider 2	

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BRIGHT FUTURES HANDOUT ▶ **PARENT**

9 AND 10 YEAR VISITS

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

HOW YOUR FAMILY IS DOING

- Encourage your child to be independent and responsible. Hug and praise him.
- Spend time with your child. Get to know his friends and their families.
- Take pride in your child for good behavior and doing well in school.
- Help your child deal with conflict.
- If you are worried about your living or food situation, talk with us. Community agencies and programs such as SNAP can also provide information and assistance.
- Don't smoke or use e-cigarettes. Keep your home and car smoke-free. Tobacco-free spaces keep children healthy.
- Don't use alcohol or drugs. If you're worried about a family member's use, let us know, or reach out to local or online resources that can help.
- Put the family computer in a central place.
- Watch your child's computer use.
  - Know who he talks with online.
  - Install a safety filter.

STAYING HEALTHY

- Take your child to the dentist twice a year.
- Give your child a fluoride supplement if the dentist recommends it.
- Remind your child to brush his teeth twice a day
  - After breakfast
  - Before bed
- Use a pea-sized amount of toothpaste with fluoride.
- Remind your child to floss his teeth once a day.
- Encourage your child to always wear a mouth guard to protect his teeth while playing sports.
- Encourage healthy eating by
  - Eating together often as a family
  - Serving vegetables, fruits, whole grains, lean protein, and low-fat or fat-free dairy
  - Limiting sugars, salt, and low-nutrient foods
- Limit screen time to 2 hours (not counting schoolwork).
- Don't put a TV or computer in your child's bedroom.
- Consider making a family media use plan. It helps you make rules for media use and balance screen time with other activities, including exercise.
- Encourage your child to play actively for at least 1 hour daily.

YOUR GROWING CHILD

- Be a model for your child by saying you are sorry when you make a mistake.
- Show your child how to use her words when she is angry.
- Teach your child to help others.
- Give your child chores to do and expect them to be done.
- Give your child her own personal space.
- Get to know your child's friends and their families.
- Understand that your child's friends are very important.
- Answer questions about puberty. Ask us for help if you don't feel comfortable answering questions.
- Teach your child the importance of delaying sexual behavior. Encourage your child to ask questions.
- Teach your child how to be safe with other adults.
  - No adult should ask a child to keep secrets from parents.
  - No adult should ask to see a child's private parts.
  - No adult should ask a child for help with the adult's own private parts.

SCHOOL

- Show interest in your child's school activities.
- If you have any concerns, ask your child's teacher for help.
- Praise your child for doing things well at school.
- Set a routine and make a quiet place for doing homework.
- Talk with your child and her teacher about bullying.

Helpful Resources: Family Media Use Plan: www.healthychildren.org/MediaUsePlan
Smoking Quit Line: 800-784-8669 | Information About Car Safety Seats: www.safercar.gov/parents | Toll-free Auto Safety Hotline: 888-327-4236

9 AND 10 YEAR VISITS—PARENT

SAFETY

- The back seat is the safest place to ride in a car until your child is 13 years old.
- Your child should use a belt-positioning booster seat until the vehicle's lap and shoulder belts fit.
- Provide a properly fitting helmet and safety gear for riding scooters, biking, skating, in-line skating, skiing, snowboarding, and horseback riding.
- Teach your child to swim and watch him in the water.
- Use a hat, sun protection clothing, and sunscreen with SPF of 15 or higher on his exposed skin. Limit time outside when the sun is strongest (11:00 am–3:00 pm).
- If it is necessary to keep a gun in your home, store it unloaded and locked with the ammunition locked separately from the gun.

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BRIGHT FUTURES HANDOUT ▶ **PATIENT**

9 AND 10 YEAR VISITS

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

TAKING CARE OF YOU

- Enjoy spending time with your family.
- Help out at home and in your community.
- If you get angry with someone, try to walk away.
- Say "No!" to drugs, alcohol, and cigarettes or e-cigarettes. Walk away if someone offers you some.
- Talk with your parents, teachers, or another trusted adult if anyone bullies, threatens, or hurts you.
- Go online only when your parents say it's OK. Don't give your name, address, or phone number on a Web site unless your parents say it's OK.
- If you want to chat online, tell your parents first.
- If you feel scared online, get off and tell your parents.

EATING WELL AND BEING ACTIVE

- Brush your teeth at least twice each day, morning and night.
- Floss your teeth every day.
- Wear your mouth guard when playing sports.
- Eat breakfast every day. It helps you learn.
- Be a healthy eater. It helps you do well in school and sports.
  - Have vegetables, fruits, lean protein, and whole grains at meals and snacks.
  - Eat when you're hungry. Stop when you feel satisfied.
  - Eat with your family often.
- Drink 3 cups of low-fat or fat-free milk or water instead of soda or juice drinks.
- Limit high-fat foods and drinks such as candies, snacks, fast food, and soft drinks.
- Talk with us if you're thinking about losing weight or using dietary supplements.
- Plan and get at least 1 hour of active exercise every day.

GROWING AND DEVELOPING

- Ask a parent or trusted adult questions about the changes in your body.
- Share your feelings with others. Talking is a good way to handle anger, disappointment, worry, and sadness.
- To handle your anger, try
  - Staying calm
  - Listening and talking through it
  - Trying to understand the other person's point of view
- Know that it's OK to feel up sometimes and down others, but if you feel sad most of the time, let us know.
- Don't stay friends with kids who ask you to do scary or harmful things.
- Know that it's never OK for an older child or an adult to
  - Show you his or her private parts.
  - Ask to see or touch your private parts.
  - Scare you or ask you not to tell your parents.
  - If that person does any of these things, get away as soon as you can and tell your parent or another adult you trust.

DOING WELL AT SCHOOL

- Try your best at school. Doing well in school helps you feel good about yourself.
- Ask for help when you need it.
- Join clubs and teams, faith groups, and friends for activities after school.
- Tell kids who pick on you or try to hurt you to stop. Then walk away.
- Tell adults you trust about bullies.

9 AND 10 YEAR VISITS—PATIENT

PLAYING IT SAFE

- Wear your lap and shoulder seat belt at all times in the car. Use a booster seat if the lap and shoulder seat belt does not fit you yet.
- Sit in the back seat until you are 13 years old. It is the safest place.
- Wear your helmet and safety gear when riding scooters, biking, skating, in-line skating, skiing, snowboarding, and horseback riding.
- Always wear the right safety equipment for your activities.
- Never swim alone. Ask about learning how to swim if you don't already know how.
- Always wear sunscreen and a hat when you're outside. Try not to be outside for too long between 11:00 am and 3:00 pm, when it's easy to get a sunburn.
- Have friends over only when your parents say it's OK.
- Ask to go home if you are uncomfortable at someone else's house or a party.
- If you see a gun, don't touch it. Tell your parents right away.

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