

American Academy of Pediatrics



BRIGHT FUTURES PREVISIT QUESTIONNAIRE

12 MONTH 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 tasks that your child is able to do.

- | | | |
|---|---|---|
| <input type="checkbox"/> Look for hidden objects. | <input type="checkbox"/> Follow a verbal command that includes a gesture. | <input type="checkbox"/> Drop objects in a cup. |
| <input type="checkbox"/> Imitate new gestures. | <input type="checkbox"/> Take first independent steps. | <input type="checkbox"/> Pick up small object with 2-finger pincer grasp. |
| <input type="checkbox"/> Say, "Dad" or "Mom" with meaning | <input type="checkbox"/> Stand without support. | <input type="checkbox"/> Pick up food and eat it. |
| <input type="checkbox"/> Use one word other than <i>Mom</i> , <i>Dad</i> , or personal names. | | |

12 MONTH VISIT

RISK ASSESSMENT

Hearing	Do you have concerns about how your child hears?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Do you have concerns about how your child speaks?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
Lead	Does your child live in or visit a home or child care facility with an identified lead hazard or a home built before 1960 that is in poor repair or that was renovated in the past 6 months?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
Oral health	Does your child's primary water source contain fluoride?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> 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)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Has your child had close contact with a person who has tuberculosis disease or who has had a positive tuberculosis test result?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Is your child infected with HIV?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
Vision	Do you have concerns about how your child sees?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Do your child's eyes appear unusual or seem to cross?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Do your child's eyelids droop or does one eyelid tend to close?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Have your child's eyes ever been injured?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure

ANTICIPATORY GUIDANCE

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

YOUR FAMILY'S HEALTH AND WELL-BEING

Living Situation and Food Security		
Do you have enough heat, hot water, electricity, and working appliances in your home?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have problems with bugs, rodents, peeling paint or plaster, mold, or dampness?	<input type="radio"/> No	<input type="radio"/> Yes
Within the past 12 months, were you ever worried whether your food would run out before you got money to buy more?	<input type="radio"/> No	<input type="radio"/> Yes
Within the past 12 months, did the food you bought not last, and you did not have money to get more?	<input type="radio"/> No	<input type="radio"/> Yes
Alcohol and Drugs		
Does anyone in your household drink beer, wine, or liquor?	<input type="radio"/> No	<input type="radio"/> Yes
Do you or other family members use marijuana, cocaine, pain pills, narcotics, or other controlled substances?	<input type="radio"/> No	<input type="radio"/> Yes
Social Connections With Family, Friends, Child Care, Home Visitation Program Staff, and Others		
Do you have child care or an adult you trust to care for your child?	<input type="radio"/> Yes	<input type="radio"/> No
Have you talked about your thoughts on feeding, sleeping, discipline, and media use with your caregiver?	<input type="radio"/> Yes	<input type="radio"/> No
Do you participate in activities outside your home? These may be social, religious, volunteer, or recreational programs.	<input type="radio"/> Yes	<input type="radio"/> No

CARING FOR YOUR CHILD

If your child is upset, do you help distract him using another activity, book, or toy?	<input type="radio"/> Yes	<input type="radio"/> No
Do you use time-outs as a way to manage your child's behavior?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have any questions about what to do when you become angry or frustrated with your child?	<input type="radio"/> No	<input type="radio"/> Yes
Does your family regularly make time for reading, playing, and talking together?	<input type="radio"/> Yes	<input type="radio"/> No
Do you eat together as a family?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have regular mealtimes and snack times?	<input type="radio"/> Yes	<input type="radio"/> No
Do you help your child feel comfortable around new people and new situations?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have regular nap time and bedtime routines for your child, such as reading books and brushing teeth?	<input type="radio"/> Yes	<input type="radio"/> No

12 MONTH VISIT

CARING FOR YOUR CHILD (CONTINUED)

Does your child watch TV or play on a tablet or smartphone? If yes, how much time each day? _____ hours	<input type="radio"/> No	<input type="radio"/> Yes
Have you made a family media use plan to help you balance media use with other family activities?	<input type="radio"/> Yes	<input type="radio"/> No

FEEDING YOUR CHILD

Does your child try feeding herself using a spoon?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child drink from a cup?	<input type="radio"/> Yes	<input type="radio"/> No
Do you give your child small, hard foods such as peanuts and popcorn?	<input type="radio"/> No	<input type="radio"/> Yes
Do you give your child round foods such as hot dogs, raw carrots, grapes, and grape tomatoes?	<input type="radio"/> No	<input type="radio"/> Yes
Do you include your child in family meals?	<input type="radio"/> Yes	<input type="radio"/> No
Have you begun to serve your child cow's milk?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child eat vegetables and fruits?	<input type="radio"/> Yes	<input type="radio"/> No
Does your child eat foods rich in protein, such as eggs, lean meat, chicken, or fish?	<input type="radio"/> Yes	<input type="radio"/> No
Do you let your child decide what and how much to eat?	<input type="radio"/> Yes	<input type="radio"/> No

HEALTHY TEETH

Do you brush your child's teeth with a smear of fluoridated toothpaste 2 times a day using a soft toothbrush?	<input type="radio"/> Yes	<input type="radio"/> No
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SAFETY

Car and Home Safety		
Is your child fastened securely in a rear-facing car safety seat in the back seat every time he rides in a vehicle?	<input type="radio"/> Yes	<input type="radio"/> No
Are you having any problems using your car safety seat?	<input type="radio"/> No	<input type="radio"/> Yes
Do you have a gate at the top and bottom of all stairs in your home?	<input type="radio"/> Yes	<input type="radio"/> No
Is the mattress in your child's crib set on the lowest setting to prevent falls?	<input type="radio"/> Yes	<input type="radio"/> No
Do you keep household cleaners, chemicals, and medicines locked up and out of your child's sight and reach?	<input type="radio"/> Yes	<input type="radio"/> No
Do all your electrical outlets have covers?	<input type="radio"/> Yes	<input type="radio"/> No
Do you keep sharp objects, plastic bags, and electrical or drapery cords out of your child's reach?	<input type="radio"/> Yes	<input type="radio"/> No
Do you keep your child away from the stove, fireplaces, and space heaters?	<input type="radio"/> Yes	<input type="radio"/> No
Are your TVs, bookcases, and dressers secured to the wall so they cannot fall over and hurt your child?	<input type="radio"/> Yes	<input type="radio"/> No
Water and Sun Safety		
Do you always stay within arm's reach of your child when he is in the bath?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have a swimming pool, pond, or lake in or near your home?	<input type="radio"/> No	<input type="radio"/> Yes
Do you put a hat on your child and apply sunscreen on her when you go outside?	<input type="radio"/> Yes	<input type="radio"/> No
Pets		
Do you own a pet?	<input type="radio"/> No	<input type="radio"/> Yes
If so, does your child interact with the pet?	<input type="radio"/> NA	<input type="radio"/> No <input type="radio"/> Yes

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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The information contained in this questionnaire should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances. Original questionnaire included as part of the *Bright Futures Tool and Resource Kit*, 2nd Edition.

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Well Child | 12 Month Visit

Accompanied By:		Preferred Language:		Date/Time:	Name:			
Weight (%):	Length (%):	Weight-for-length (%):		HC (%):	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

Solids:

Nutrition (continued):

☐ Breastfeeding: _____ ☐ Formula: Ounces per 24 hours: _____

☐ Milk: Source: _____ Ounces per 24 hours: _____

Drinks from: ☐ Cup ☐ Bottle ☐ Both

Dental Home: ☐ No ☐ Yes: _____

Brushing twice daily: ☐ Yes ☐ No: _____

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

Elimination: ☐ Regular soft stools

Sleep: ☐ No concerns

Behavior: ☐ No concerns

Physical Activity:

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

Screen time: ☐ None h/d: _____

Source: _____

DEVELOPMENT

☒ = Normal development ☐ See Previsit Questionnaire.

Caregiver concerns about development: ☐ None ☐ Yes: _____

☐ SOCIAL LANGUAGE AND SELF-HELP

- Looks for hidden objects
- Imitates new gestures

☐ VERBAL LANGUAGE

- Says, "Dad" or "Mom" with meaning
- Uses one word other than *Mom* or *Dad*, or personal names
- Follows a verbal command that includes a gesture

☐ GROSS MOTOR

- Takes first independent steps
- Stands without support

☐ FINE MOTOR

- Drops object in a cup
- Picks up small object with 2-finger pincer grasp
- Picks up food and eats it

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SOCIAL AND FAMILY HISTORY

Areas reviewed and updated as needed (See Initial History Questionnaire.): ☐ Social History ☐ Family HistoryChanges since last visit: _____ ☐ No interval changeSmoking household: ☐ No ☐ Yes: _____Firearms in home: ☐ No ☐ Yes: _____

Observation of parent-child interaction: _____

Parents working outside home: ☐ One parent ☐ Both parents Child care: ☐ No ☐ Yes Type: _____

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 VisitConstitutional: _____ **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:** Alert, active child. **Normal interval growth in height, weight, and head circumference. Normal weight-for-length for age.**☐ **Head:** Normocephalic and atraumatic. Normal sutures. Anterior fontanelle open and flat. _____☐ **Eyes:** **Fixes and follows. Extraocular eye movements intact. No strabismus. Red reflex present bilaterally. No opacification.**

Normal funduscopic examination findings. _____

☐ Ears, nose, **mouth**, and throat: Tympanic membranes with visible light reflex bilaterally. Healthy-appearing teeth **without caries, plaque, or discoloration.**☐ 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. **Labia open.** _____☐ Normal male external genitalia, with **testes descended bilaterally.** _____☐ Musculoskeletal: Spine straight. Normal hip abduction. _____☐ **Neurological:** **Moves all extremities equally. Normal hand grasp and strength. Age-appropriate gait** (If walking). _____☐ **Skin:** Warm and well perfused. **No lesions (atypical nevi, café-au-lait spots, or birthmarks) or bruising.** _____

Other comments: _____

ASSESSMENT

☐ Well child ☐ Normal interval growth (See growth chart.) ☐ Normal weight-for-length percentile for age ☐ Age-appropriate development

ANTICIPATORY GUIDANCE

☒ Discussed and/or handout given☐ **SOCIAL DETERMINANTS OF HEALTH**

- Living situation and food security
- Tobacco, alcohol, and drug use
- Social connections with family and others

☐ **ESTABLISHING A DENTAL HOME**

- First dental checkup and dental hygiene

☐ **ESTABLISHING ROUTINES**

- Adjustment to development changes and behavior
- Family time
- Bedtime, nap time, and teeth brushing
- Media

☐ **FEEDING AND APPETITE CHANGES**

- Self-feeding
- Continued breastfeeding; transition to family meals
- Nutritious foods

☐ **SAFETY**

- Car safety seats
- Falls
- Drowning prevention and water safety
- Sun protection
- Pets
- Poisoning

PLAN

Immunizations: ☐ Vaccine Administration Record reviewed Administered today: _____ ☐ Up-to-date for age
Universal Screening:
☐ Anemia: Result: ☐ Within reference range: _____ ☐ Low: _____ Follow-up: _____

☐ Lead (Medicaid or high prevalence area): ☐ Pending/sent to lab Result: ☐ Within reference range: _____ ☐ Elevated: _____

Follow-up: _____

☐ Oral health: Fluoride varnish applied: ☐ Yes ☐ No: _____ Oral fluoride supplementation: ☐ Yes ☐ No: _____ ☐ NA
Selective Screening (based on risk assessment) (See Previsit Questionnaire.):
☐ BP ☐ Hearing ☐ Oral health ☐ Lead (non-Medicaid or low prevalence area) ☐ Tuberculosis ☐ Vision

Comments/results:

Follow-up:
☐ Routine follow-up at 15 months ☐ Next visit: _____ ☐ Referral to: _____

PRINT NAME.	SIGNATURE
Provider 1	
Provider 2	

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BRIGHT FUTURES HANDOUT ► PARENT

12 MONTH VISIT

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

✓ HOW YOUR FAMILY IS DOING

- If you are worried about your living or food situation, reach out for help. Community agencies and programs such as WIC and SNAP can 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.
- Make sure everyone who cares for your child offers healthy foods, avoids sweets, provides time for active play, and uses the same rules for discipline that you do.
- Make sure the places your child stays are safe.
- Think about joining a toddler playgroup or taking a parenting class.
- Take time for yourself and your partner.
- Keep in contact with family and friends.

✓ ESTABLISHING ROUTINES

- Praise your child when he does what you ask him to do.
- Use short and simple rules for your child.
- Try not to hit, spank, or yell at your child.
- Use short time-outs when your child isn't following directions.
- Distract your child with something he likes when he starts to get upset.
- Play with and read to your child often.
- Your child should have at least one nap a day.
- Make the hour before bedtime loving and calm, with reading, singing, and a favorite toy.
- Avoid letting your child watch TV or play on a tablet or smartphone.
- Consider making a family media plan. It helps you make rules for media use and balance screen time with other activities, including exercise.

✓ FEEDING YOUR CHILD

- Offer healthy foods for meals and snacks. Give 3 meals and 2 to 3 snacks spaced evenly over the day.
- Avoid small, hard foods that can cause choking—popcorn, hot dogs, grapes, nuts, and hard, raw vegetables.
- Have your child eat with the rest of the family during mealtime.
- Encourage your child to feed herself.
- Use a small plate and cup for eating and drinking.
- Be patient with your child as she learns to eat without help.
- Let your child decide what and how much to eat. End her meal when she stops eating.
- Make sure caregivers follow the same ideas and routines for meals that you do.

✓ FINDING A DENTIST

- Take your child for a first dental visit as soon as her first tooth erupts or by 12 months of age.
- Brush your child's teeth twice a day with a soft toothbrush. Use a small smear of fluoride toothpaste (no more than a grain of rice).
- If you are still using a bottle, offer only water.

Helpful Resources: Smoking Quit Line: 800-784-8669 | Family Media Use Plan: www.healthychildren.org/MediaUsePlan

Poison Help Line: 800-222-1222 | Information About Car Safety Seats: www.safercar.gov/parents | Toll-free Auto Safety Hotline: 888-327-4236

12 MONTH VISIT—PARENT

✓ SAFETY

- Make sure your child's car safety seat is rear facing until he reaches the highest weight or height allowed by the car safety seat's manufacturer. In most cases, this will be well past the second birthday.
- Never put your child in the front seat of a vehicle that has a passenger airbag. The back seat is safest.
- Place gates at the top and bottom of stairs. Install operable window guards on windows at the second story and higher. Operable means that, in an emergency, an adult can open the window.
- Keep furniture away from windows.
- Make sure TVs, furniture, and other heavy items are secure so your child can't pull them over.
- Keep your child within arm's reach when he is near or in water.
- Empty buckets, pools, and tubs when you are finished using them.
- Never leave young brothers or sisters in charge of your child.
- When you go out, put a hat on your child, have him wear sun protection clothing, and apply 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).
- Keep your child away when your pet is eating. Be close by when he plays with your pet.
- Keep poisons, medicines, and cleaning supplies in locked cabinets and out of your child's sight and reach.
- Keep cords, latex balloons, plastic bags, and small objects, such as marbles and batteries, away from your child. Cover all electrical outlets.
- Put the Poison Help number into all phones, including cell phones. Call if you are worried your child has swallowed something harmful. Do not make your child vomit.

WHAT TO EXPECT AT YOUR CHILD'S 15 MONTH VISIT

We will talk about

- Supporting your child's speech and independence and making time for yourself
- Developing good bedtime routines
- Handling tantrums and discipline
- Caring for your child's teeth
- Keeping your child safe at home and in the car

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