PATIENT NAME: _____ **DATE:** _____

Please print.

American Academy of Pediatrics

BRIGHT FUTURES PREVISIT QUESTIONNAIRE
15 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.

- ☐ Imitate scribbling.
- ☐ Drink from cup with little spilling.
- ☐ Point to ask for something or to get help.
- ☐ Look around when you say things such as "Where's your ball?" and "Where's your blanket?"
- ☐ Use 3 words other than names.
- ☐ Speak in sounds that seem like an unknown language.
- ☐ Follow directions that do not include a gesture.
- ☐ Squat to pick up objects.
- ☐ Crawl up a few steps.
- ☐ Run.
- ☐ Make marks with a crayon.
- ☐ Drop an object into and take the object out of a container.

PATIENT NAME: _____ **DATE:** _____

Please print.

15 MONTH 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
	Do you ever struggle to put food on the table?	O No	O Yes	O Unsure
Hearing	Do you have concerns about how your child hears?	O No	O Yes	O Unsure
	Do you have concerns about how your child speaks?	O No	O Yes	O Unsure
Vision	Do you have concerns about how your child sees?	O No	O Yes	O Unsure
	Do your child's eyes appear unusual or seem to cross?	O No	O Yes	O Unsure
	Do your child's eyelids droop or does one eyelid tend to close?	O No	O Yes	O Unsure
	Have your child's eyes ever been injured?	O No	O Yes	O Unsure

ANTICIPATORY GUIDANCE

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

TALKING AND FEELING

Is your child learning new things?	O Yes	O No
Does your child show any worries or fears when meeting new people?	O No	O Yes
Do you take time for yourself?	O Yes	O No
Do you spend time alone with your partner?	O Yes	O No
Does your child point to something he wants and then watch to see if you see what he's doing?	O Yes	O No
Does she wave "bye-bye"?	O Yes	O No
Do you talk to, sing to, and look at books with your child every day?	O Yes	O No

SLEEP ROUTINES AND ISSUES

Does your child have a regular bedtime routine?	O Yes	O No
Does your child sleep well?	O Yes	O No
How many hours does your child sleep? _____ Daytime ____ Nighttime		
Does your child have a blanket, stuffed animal, or toy that he likes to sleep with?	O Yes	O No
Do you have a TV or an Internet-connected device in your child's bedroom?	O No	O Yes

TANTRUMS AND DISCIPLINE

Does your child have frequent tantrums?	O No	O Yes
If your child is upset, do you help distract her with another activity, book, or toy?	O Yes	O No
Do you set limits for your child?	O Yes	O No
Do other caregivers set the same limits for your child as you do?	O Yes	O No
Do you praise your child when he is being good?	O Yes	O No
Do you have any questions about what to do when you become angry or frustrated with your child?	O No	O Yes

HEALTHY TEETH

Has your child been to a dentist?	O Yes	O No
Do you brush your child's teeth with a smear of fluoridated toothpaste 2 times a day using a soft toothbrush?	O Yes	O No
Does your child use a bottle?	O No	O Yes

PATIENT NAME: _____ **DATE:** _____

Please print.

15 MONTH VISIT

SAFETY

Car and Home Safety		
Is your child fastened securely in a rear-facing car safety seat 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, booster seat, or car safety seat?	○ Yes	○ No
Do you keep cleaners and medicines locked up and out of your child's sight and reach?	○ Yes	○ No
Do you have emergency phone numbers near every telephone and in your cell phone for rapid dial?	○ Yes	○ No
Do you keep furniture away from windows and use operable window guards on windows on the second floor and higher? (Operable means that, in case of an emergency, an adult can open the window.)	○ Yes	○ No
Do you have a gate at the top and bottom of all stairs in your home?	○ Yes	○ No
Do you keep cigarettes, lighters, matches, and alcohol out of your child's sight and reach?	○ Yes	○ No
Do you keep your child away from the stove?	○ Yes	○ No
Do you have working smoke alarms on every floor of your home?	○ Yes	○ No
Do you test the batteries once a month?	○ Yes	○ No
Do you have a fire escape plan?	○ Yes	○ No

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

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Well Child | 15 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

☐ Daily fruits and vegetables: ☐ Iron source: _____

Comments:

Nutrition (*continued*):

☐ Milk: Source: _____ Drinks from: ☐ Breast ☐ Bottle ☐ Cup

Ounces per 24 hours: _____

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
- Imitates scribbling
- Drinks from cup with little spilling
- Points to ask for something or to get help

☐ VERBAL LANGUAGE
- Uses 3 words other than names
- Speaks in sounds that seem like an unknown language
- Follows directions that do not include a gesture
- Looks around when parent says, "Where is…?"

☐ GROSS MOTOR
- Squats to pick up objects
- Crawls up a few steps
- Begins to run

☐ FINE MOTOR
- Makes mark with crayon
- Drops object into and takes object out of container

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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 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 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:** Alert, active child. **Normal interval growth in height, weight, and head circumference. Normal weight-for-length for age.**

☐ **Head:** Normocephalic and atraumatic. _____

☐ **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. _____
- ☐ 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.**

☐ **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

Name: _____

ANTICIPATORY GUIDANCE

☑ Discussed and/or handout given

☐ **COMMUNICATION AND SOCIAL DEVELOPMENT**
- Individuation
- Separation
- Finding support
- Attention to how child communicates wants and interests

☐ **TEMPERAMENT, DEVELOPMENT, BEHAVIOR, AND DISCIPLINE**
- Conflict predictors and distraction
- Discipline and behavior management

☐ **SLEEP ROUTINES AND ISSUES**
- Regular bedtime routine
- Night waking
- No bottle in bed

☐ **HEALTHY TEETH**
- Brushing teeth
- Reducing caries

☐ **SAFETY**
- Car safety seats and parental use of seat belts
- Safe home environment: poisoning, falls, and fire safety

PLAN

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

Universal Screening:

☐ Oral health: Fluoride varnish applied: ☐ Yes ☐ No: _____ Oral fluoride supplementation: ☐ Yes ☐ No: _____ ☐ NA

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

☐ Anemia ☐ BP ☐ Hearing ☐ Vision

Comments/results:

Follow-up:

☐ Routine follow-up at 18 months ☐ Next visit: _____ ☐ Referral to: _____

PRINT NAME.	SIGNATURE
Provider 1	
Provider 2	

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BRIGHT FUTURES HANDOUT ▶ **PARENT**

15 MONTH VISIT

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

TALKING AND FEELING

- Try to give choices. Allow your child to choose between 2 good options, such as a banana or an apple, or 2 favorite books.
- Know that it is normal for your child to be anxious around new people. Be sure to comfort your child.
- Take time for yourself and your partner.
- Get support from other parents.
- Show your child how to use words.
  - Use simple, clear phrases to talk to your child.
  - Use simple words to talk about a book's pictures when reading.
  - Use words to describe your child's feelings.
  - Describe your child's gestures with words.

TANTRUMS AND DISCIPLINE

- Use distraction to stop tantrums when you can.
- Praise your child when she does what you ask her to do and for what she can accomplish.
- Set limits and use discipline to teach and protect your child, not to punish her.
- Limit the need to say "No!" by making your home and yard safe for play.
- Teach your child not to hit, bite, or hurt other people.
- Be a role model.

A GOOD NIGHT'S SLEEP

- Put your child to bed at the same time every night. Early is better.
- Make the hour before bedtime loving and calm.
- Have a simple bedtime routine that includes a book.
- Try to tuck in your child when he is drowsy but still awake.
- Don't give your child a bottle in bed.
- Don't put a TV, computer, tablet, or smartphone in your child's bedroom.
- Avoid giving your child enjoyable attention if he wakes during the night. Use words to reassure and give a blanket or toy to hold for comfort.

HEALTHY TEETH

- Take your child for a first dental visit if you have not done so.
- Brush your child's teeth twice each day with a small smear of fluoridated toothpaste, no more than a grain of rice.
- Wean your child from the bottle.
- Brush your own teeth. Avoid sharing cups and spoons with your child. Don't clean her pacifier in your mouth.

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

15 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 the safest.
- Everyone should wear a seat belt in the car.
- Keep poisons, medicines, and lawn and cleaning supplies in locked cabinets, out of your child's sight and reach.
- Put the Poison Help number into all phones, including cell phones. Call if you are worried your child has swallowed something harmful. Don't make your child vomit.
- Place gates at the top and bottom of stairs. Install operable window guards on windows at the second story and higher. Keep furniture away from windows.
- Turn pan handles toward the back of the stove.
- Don't leave hot liquids on tables with tablecloths that your child might pull down.
- Have working smoke and carbon monoxide alarms on every floor. Test them every month and change the batteries every year. Make a family escape plan in case of fire in your home.

WHAT TO EXPECT AT YOUR CHILD'S 18 MONTH VISIT

We will talk about

- Handling stranger anxiety, setting limits, and knowing when to start toilet training
- Supporting your child's speech and ability to communicate
- Talking, reading, and using tablets or smartphones with your child
- Eating healthy
- Keeping your child safe at home, outside, and in the car

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