PATIENT NAME: _____ **DATE:** _____

Please print.

American Academy of Pediatrics

BRIGHT FUTURES PREVISIT QUESTIONNAIRE
2 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. **Autism Spectrum Disorder screening is also part of this visit.** 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.

- ☐ Play with other children and express interest in their play.
- ☐ Take off some clothing.
- ☐ Scoop well with a spoon.
- ☐ Use 50 words.
- ☐ Combine 2 words into a short phrase or sentence.
- ☐ Follow a 2-step command (such as "Pick it up and put it away").
- ☐ Name at least 5 body parts.
- ☐ Speak so strangers can understand 50% of what he says.
- ☐ Kick a ball.
- ☐ Jump off the ground with 2 feet.
- ☐ Run with coordination.
- ☐ Climb up a ladder at a playground.
- ☐ Stack objects.
- ☐ Turn book pages.
- ☐ Use his hands to turn objects.
- ☐ Draw lines.

PATIENT NAME: _____ **DATE:** _____

Please print.

2 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
	Do you ever struggle to put food on the table?	O No	O Yes	O Unsure
Dyslipidemia	Does your child have parents, grandparents, or aunts or uncles who have had a stroke or heart problem before age 55 (male) or 65 (female)?	O No	O Yes	O Unsure
	Does your child have a parent with elevated blood cholesterol level (240 mg/dL or higher) or who is taking cholesterol medication?	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
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 was renovated in the past 6 months?	O No	O Yes	O Unsure
Oral health	Does your child have a dentist?	O Yes	O No	O Unsure
	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
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?

YOUR FAMILY'S HEALTH AND WELL-BEING

Intimate Partner Violence		
Do you always feel safe in your home?	O Yes	O No
Has your partner, or another significant person in your life, ever hit, kicked, or shoved you, or physically hurt you or your child?	O No	O Yes
Living Situation and Food Security		
Is permanent housing a worry for you?	O No	O Yes
Do you have the things you need to take care of your child?	O Yes	O No
Does your home have enough heat, hot water, electricity, and working appliances?	O Yes	O No
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
Alcohol and Drugs		
Does anyone in your household drink beer, wine, or liquor?	O No	O Yes
Do you or other family members use marijuana, cocaine, pain pills, narcotics, or other controlled substances?	O No	O Yes
Taking Care of Yourself		
Do you take time for yourself?	O Yes	O No
Do you and your partner spend time alone together?	O Yes	O No
Do you and your family do activities together?	O Yes	O No
Do you have someone you can turn to if you need to talk about problems?	O Yes	O No

PATIENT NAME: _____ **DATE:** _____

Please print.

2 YEAR VISIT

YOUR CHILD'S BEHAVIOR

Is your child learning new things?	O Yes	O No
Do you spend time alone with your child doing something that he likes to do?	O Yes	O No
Do you encourage other family members and caregivers to be consistent, patient, and calm with your child?	O Yes	O No
Do you show your child how to be physically active every day by playing and being active with her?	O Yes	O No
Does your child play with other children?	O Yes	O No
How much time every day does your child spend watching TV or using computers, tablets, or smartphones?	_____ hours	

TALKING AND YOUR CHILD

Does your child have ways to tell you what he wants?	O Yes	O No
Do you use simple words when asking your child a question or telling her what to do?	O Yes	O No
Do you give your child plenty of time to respond?	O Yes	O No
Do you sing songs and talk with your child about the things you do together?	O Yes	O No
Do you read to your child or look at books together every day?	O Yes	O No

TOILET TRAINING

Is your child interested in using the toilet?	O Yes	O No
Does your child tell you when he has a bowel movement?	O Yes	O No
Is your child dry for about 2 hours at a time?	O Yes	O No
Does your child know the difference between being wet and dry?	O Yes	O No
Do you help your child wash her hands after going to the bathroom?	O Yes	O No

SAFETY

Car Safety		
Is your child fastened securely in a rear-facing car safety seat in the back seat every time he rides in a vehicle?	O Yes	O No
Does everyone in the vehicle always use a lap and shoulder seat belt, booster seat, or car safety seat?	O Yes	O No
Outdoor Safety		
Does your child always wear a bike helmet when she rides on a tricycle, in a towed bike trailer, or in a seat on an adult's bicycle?	O Yes	O No
Do you keep your child away from moving machines, lawn mowers, driveways, and streets?	O Yes	O No
Do you live near any backyard swimming pools, hot tubs, or spas?	O No	O Yes
Gun Safety		
Does anyone in your home or the homes where your child spends time have a gun?	O No	O Yes
If yes, is the gun unloaded and locked up?	O Yes	O No
If yes, is the ammunition stored and locked up separately from the gun?	O Yes	O No

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

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Well Child | 2 Year Visit

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

Dental Home: ☐ No ☐ Yes: _____

Brushing twice daily: ☐ Yes ☐ No: _____

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

_____

Elimination: ☐ Regular soft stools

Toilet-trained: ☐ Yes ☐ No ☐ In process

Sleep: ☐ No concerns

Behavior: ☐ No concerns

Physical Activity:

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

Screen time: ☐ None h/d: _____

Source: _____ Quality monitored: ☐ Yes ☐ No

DEVELOPMENT

☑ = Normal development ☐ See Previsit Questionnaire.

Caregiver concerns about development: ☐ None ☐ Yes: _____

☐ SOCIAL LANGUAGE AND SELF-HELP
- Plays alongside other children
- Takes off some clothing
- Scoops well with spoon

☐ VERBAL LANGUAGE
- Uses 50 words
- Combines 2 words into phrase or sentence
- Follows 2-step command
- Uses words that are 50% intelligible to strangers

☐ GROSS MOTOR
- Kicks ball
- Jumps off ground with 2 feet
- Runs with coordination
- Climbs up a ladder at a playground

☐ FINE MOTOR
- Stacks objects
- Turns book pages
- Uses hands to turn objects (eg, knobs, toys, lids)

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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 and weight. Normal weight-for-length or BMI for age.**

☐ Head: Normocephalic and atraumatic. _____

☐ **Eyes: Fixes and follows. Extraocular eye movements intact. 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, discoloration, or breakage.** No oral lesions **or gingivitis.**

☐ 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. Full range of motion. _____

☐ **Neurological: Normal gait and running for age. Follows commands, scribbles, and is social. Communicates with words.**

☐ **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 or BMI percentile for age ☐ Age-appropriate development

Name: _____

ANTICIPATORY GUIDANCE

☑ Discussed and/or handout given

☐ **SOCIAL DETERMINANTS OF HEALTH**
- Intimate partner violence
- Living situation and food security
- Tobacco, alcohol, and drug use
- Parental well-being

☐ **TOILET TRAINING**
- Techniques
- Personal hygiene

☐ **TEMPERAMENT AND BEHAVIOR**
- Development
- Temperament
- Promotion of physical activity and safe play
- Limits on media use

☐ **ASSESSMENT OF LANGUAGE DEVELOPMENT**
- How child communicates and expectations for language
- Promotion of reading

☐ **SAFETY**
- Car safety seats
- Outdoor safety
- Gun safety

PLAN

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

Universal Screening:

☐ Autism screening: Screening tool used: _____ Result: ☐ Passed ☐ Failed: _____

☐ 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.):

☐ Anemia ☐ BP ☐ Dyslipidemia ☐ Hearing ☐ Lead (non-Medicaid or low prevalence area) ☐ Oral health ☐ Tuberculosis ☐ Vision

Comments/results:

Follow-up:

☐ Routine follow-up at 2½ years ☐ Next visit: _____ ☐ Referral to: _____

PRINT NAME.	SIGNATURE
Provider 1	
Provider 2	

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BRIGHT FUTURES HANDOUT ▶ **PARENT**

2 YEAR VISIT

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

HOW YOUR FAMILY IS DOING

- Take time for yourself and your partner.
- Stay in touch with friends.
- Make time for family activities. Spend time with each child.
- Teach your child not to hit, bite, or hurt other people. Be a role model.
- If you feel unsafe in your home or have been hurt by someone, let us know. Hotlines and community resources can also provide confidential help.
- 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.
- Accept help from family and friends.
- 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.

TALKING AND YOUR CHILD

- Use clear, simple language with your child. Don't use baby talk.
- Talk slowly and remember that it may take a while for your child to respond. Your child should be able to follow simple instructions.
- Read to your child every day. Your child may love hearing the same story over and over.
- Talk about and describe pictures in books.
- Talk about the things you see and hear when you are together.
- Ask your child to point to things as you read.
- Stop a story to let your child make an animal sound or finish a part of the story.

YOUR CHILD'S BEHAVIOR

- Praise your child when he does what you ask him to do.
- Listen to and respect your child. Expect others to as well.
- Help your child talk about his feelings.
- Watch how he responds to new people or situations.
- Read, talk, sing, and explore together. These activities are the best ways to help toddlers learn.
- Limit TV, tablet, or smartphone use to no more than 1 hour of high-quality programs each day.
  - It is better for toddlers to play than to watch TV.
  - Encourage your child to play for up to 60 minutes a day.
- Avoid TV during meals. Talk together instead.

TOILET TRAINING

- Begin toilet training when your child is ready. Signs of being ready for toilet training include
  - Staying dry for 2 hours
  - Knowing if she is wet or dry
  - Can pull pants down and up
  - Wanting to learn
  - Can tell you if she is going to have a bowel movement
- Plan for toilet breaks often. Children use the toilet as many as 10 times each day.
- Teach your child to wash her hands after using the toilet.
- Clean potty-chairs after every use.
- Take the child to choose underwear when she feels ready to do so.

Helpful Resources: National Domestic Violence Hotline: 800-799-7233 | Smoking Quit Line: 800-784-8669
Information About Car Safety Seats: www.safercar.gov/parents | Toll-free Auto Safety Hotline: 888-327-4236

2 YEAR 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. Once your child reaches these limits, it is time to switch the seat to the forward-facing position.
- Make sure the car safety seat is installed correctly in the back seat. The harness straps should be snug against your child's chest.
- Children watch what you do. Everyone should wear a lap and shoulder seat belt in the car.
- Never leave your child alone in your home or yard, especially near cars or machinery, without a responsible adult in charge.
- When backing out of the garage or driving in the driveway, have another adult hold your child a safe distance away so he is not in the path of your car.
- Have your child wear a helmet that fits properly when riding bikes and trikes.
- If it is necessary to keep a gun in your home, store it unloaded and locked with the ammunition locked separately.

WHAT TO EXPECT AT YOUR CHILD'S 2½ YEAR VISIT

We will talk about

- Creating family routines
- Supporting your talking child
- Getting along with other children
- Getting ready for preschool
- Keeping your child safe at home, outside, and in the car

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