PATIENT NAME: _____ **DATE:** _____

Please print.

American Academy of Pediatrics

BRIGHT FUTURES PREVISIT QUESTIONNAIRE
5 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 tasks that your child is able to do.

- ☐ Is beginning to skip.
- ☐ Walk on tiptoes when asked.
- ☐ Catch a bounced ball with 2 hands.
- ☐ Copy a triangle.
- ☐ Draw a 6-part person.
- ☐ Copy first name.
- ☐ Cut well with scissors.
- ☐ Spread with a knife.
- ☐ Dress and undress without help.
- ☐ Urinate and have a bowel movement on her own.
- ☐ Is dry through the day.
- ☐ Tell a story of 2 sentences or more.
- ☐ Follow directions for 4 individual prepositions, such as *on, under, behind,* and *in front of.*
- ☐ Play and interact with peers.
- ☐ Answer "why" questions.
- ☐ Count 5 objects.
- ☐ Name 3 or more single numbers.
- ☐ Name 4 or more letters out of alphabetic order.
- ☐ Write 2 or more letters.

PATIENT NAME: _____ **DATE:** _____

Please print.

5 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
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

ANTICIPATORY GUIDANCE

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

YOUR FAMILY'S HEALTH AND WELL-BEING

Neighborhood and Family Violence (Bullying and Fighting)		
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 ever bullied or been aggressive with others?	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
Alcohol and Drugs		
Is there anyone in your child's life whose alcohol or drug use concerns you?	O No	O Yes
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
Connectedness With Family		
Does your family get along well with each other?	O Yes	O No
Does your family do things together?	O Yes	O No

FAMILY RULES AND ROUTINES

Does your child have chores or responsibilities at home?	O Yes	O No
Do you have clear rules and expectations for your child?	O Yes	O No
When your child breaks the rules, are you consistent with consequences and discipline?	O Yes	O No
Do you let your child know when she is being good?	O Yes	O No
Does your child have problems dealing with angry feelings?	O No	O Yes
Do you help your child control his anger?	O Yes	O No

SCHOOL

Did your child attend a preschool program?		O Yes	O No
Has your child started elementary school?		O Yes	O No
Do you have any concerns about your child's school experience?	O NA	O No	O Yes

PATIENT NAME: _____ **DATE:** _____

Please print.

5 YEAR VISIT

SCHOOL (*CONTINUED*)

Are you able to attend activities or functions at your child's school?	○ NA	○ Yes	○ No
Is your child involved in after-school activities?	○ NA	○ Yes	○ No
Does your child receive any special education services?		○ No	○ Yes

STAYING HEALTHY

Healthy Teeth		
Does your child brush his teeth twice a day?	○ Yes	○ No
Does your child see the dentist twice a year?	○ Yes	○ No
Nutrition		
Do you have any concerns about your child's eating? This includes drinking enough milk and eating vegetables and fruits.	○ No	○ Yes
Does your child drink soda, juice, or other sugar-sweetened drinks?	○ No	○ Yes
Does your child eat breakfast every day?	○ Yes	○ No
Physical Activity		
Is your child physically active at least 1 hour every day? This includes running, playing sports, or active play with friends.	○ Yes	○ No
How much time every day does your child spend watching TV 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
Does your child have trouble going to sleep or does he wake up during the night?	○ No	○ Yes
Does your child have a regular bedtime?	○ Yes	○ No

SAFETY

Car Safety		
Is your child fastened securely in a car safety seat or belt-positioning booster seat in the back seat every time he rides in a vehicle?	○ Yes	○ No
Does everyone else in the vehicle always use a lap and shoulder seat belt, booster seat, or car safety seat?	○ Yes	○ No
Outdoor Safety		
Does your child always wear a helmet to protect her head when biking, skating, or doing other outdoor activities?	○ Yes	○ No
Does your child know street safety habits, such as stopping at the curb, looking both ways, and never crossing the street without a grown-up?	○ Yes	○ No
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
Home Fire Safety		
Do you have working smoke alarms installed on every level of your home?	○ Yes	○ No
Do you have carbon monoxide detectors/alarms in your home?	○ Yes	○ No
Do you have an emergency escape plan in case of fire?	○ Yes	○ No
Does your child know what to do if the fire alarm rings?	○ Yes	○ No

PATIENT NAME: _____ **DATE:** _____

Please print.

5 YEAR VISIT

SAFETY (*CONTINUED*)

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
Harm From Adults		
Have you taught your child that it is never OK for an adult to tell a child to keep secrets from her parents?	○ Yes	○ No
Does your child know that it is never OK for an older child or an adult to ask to see his private parts?	○ 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 | 5 Year Visit

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:

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:

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

Screen time: h/d: _____

Source: _____ Quality monitored: ☐ Yes ☐ No

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

DEVELOPMENT

☑ = Normal development ☐ See Previsit Questionnaire.

Caregiver concerns about development: ☐ None ☐ Yes: _____

☐ SOCIAL LANGUAGE AND SELF-HELP
- Spreads with a knife
- Dresses and undresses without help
- Goes to bathroom independently
- Is dry through the day
- Plays and interacts with peers
- Answers "why" questions

☐ VERBAL LANGUAGE
- Tells a story of 2 sentences or more
- Follows directions for 4 individual prepositions
- Counts 5 objects
- Names 3 or more numbers
- Names 4 or more letters out of order

☐ GROSS MOTOR
- Is beginning to skip
- Walks on tiptoes when asked
- Catches a bounced ball with 2 hands

☐ FINE MOTOR
- Copies a triangle
- Draws a 6-part person
- Copies first name
- Cuts well with scissors
- Writes 2 or more letters

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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. No gingivitis. No malocclusion.**

☐ 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. Fine motor skills appropriate for age.** _____

☐ **Skin:** Warm and well perfused. No rashes or bruising. No atypical nevi or birthmarks. _____

Other comments: _____

ASSESSMENT

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

☐ Age-appropriate development

Name: _____

ANTICIPATORY GUIDANCE

☑ Discussed and/or handout given

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

☐ **DEVELOPMENT AND MENTAL HEALTH**
- Family rules and routines, concern for others, and respect for others
- Patience and control over anger

☐ **SCHOOL**
- Readiness, established routines, school attendance, and friends
- After-school care and activities; parent-teacher communication

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

☐ **SAFETY**
- Car safety
- Outdoor safety
- Water safety
- Sun protection
- Harm from adults
- Home fire safety
- Gun safety

PLAN

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

Universal Screening:

☐ Hearing: Result: ☐ Unable to complete ☐ Normal hearing BL ☐ Abnormal: _____

☐ Vision: Result: ☐ Unable to complete ☐ Normal vision for age ☐ Abnormal: _____

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

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

☐ Anemia ☐ Lead ☐ Oral health ☐ Tuberculosis

Comments/results:

Follow-up:

☐ Routine follow-up at 6 years ☐ Next visit: _____ ☐ Referral to: _____

PRINT NAME.	SIGNATURE
Provider 1	
Provider 2	

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BRIGHT FUTURES HANDOUT ▶ **PARENT**

5 AND 6 YEAR VISITS

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

HOW YOUR FAMILY IS DOING

- Spend time with your child. Hug and praise him.
- Help your child do things for himself.
- 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.

FAMILY RULES AND ROUTINES

- Family routines create a sense of safety and security for your child.
- Teach your child what is right and what is wrong.
- Give your child chores to do and expect them to be done.
- Use discipline to teach, not to punish.
- Help your child deal with anger. Be a role model.
- Teach your child to walk away when she is angry and do something else to calm down, such as playing or reading.

STAYING HEALTHY

- Help your child brush his teeth twice a day
  - After breakfast
  - Before bed
- Use a pea-sized amount of toothpaste with fluoride.
- Help your child floss his teeth once a day.
- Your child should visit the dentist at least twice a year.
- Help your child be a healthy eater by
  - Providing healthy foods, such as vegetables, fruits, lean protein, and whole grains
  - Eating together as a family
  - Being a role model in what you eat
- Buy fat-free milk and low-fat dairy foods. Encourage 2 to 3 servings each day.
- Limit candy, soft drinks, juice, and sugary foods.
- Make sure your child is active for 1 hour or more daily.
- Don't put a TV in your child's bedroom.
- Consider making a family media plan. It helps you make rules for media use and balance screen time with other activities, including exercise.

READY FOR SCHOOL

- Talk to your child about school.
- Read books with your child about starting school.
- Take your child to see the school and meet the teacher.
- Help your child get ready to learn. Feed her a healthy breakfast and give her regular bedtimes so she gets at least 10 to 11 hours of sleep.
- Make sure your child goes to a safe place after school.
- If your child has disabilities or special health care needs, be active in the Individualized Education Program process.

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

5 AND 6 YEAR VISITS—PARENT

SAFETY

- Your child should always ride in the back seat (until at least 13 years of age) and use a forward-facing car safety seat or belt-positioning booster seat.
- Teach your child how to safely cross the street and ride the school bus. Children are not ready to cross the street alone until 10 years or older.
- Provide a properly fitting helmet and safety gear for riding scooters, biking, skating, in-line skating, skiing, snowboarding, and horseback riding.
- Make sure your child learns to swim. Never let your child swim alone.
- 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).
- Teach your child about 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.
- 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.
- If it is necessary to keep a gun in your home, 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.

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