Bright Futures Previsit Questionnaire
8 Year Visit

For us to provide your child with the best possible health care, we would like to know how things are going.
Please answer all of 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?

We are interested in answering your questions. Please check off the boxes for the topics you would like to discuss the most today.

School	☐ How your child is learning and doing in school ☐ Bullying ☐ After-school activities and care ☐ Special education needs ☐ How your child acts ☐ Talking with your child's school
Your Growing Child	☐ How your child feels about herself ☐ Following rules ☐ Getting ready for puberty ☐ Being angry ☐ Your child dealing with his problems ☐ Becoming more independent
Staying Healthy	☐ Your child's weight ☐ 1 hour of physical activity daily ☐ Playing sports ☐ TV time ☐ Getting enough calcium ☐ Drinking enough water ☐ How much your child should eat at one time
Healthy Teeth	☐ Regular dentist visits ☐ Brushing teeth twice daily ☐ Flossing daily
Safety	☐ Booster seats ☐ Helmets and sports safety ☐ Swimming safety ☐ Wearing sunscreen ☐ Knowing your child's computer use ☐ Knowing your child's friends and their families ☐ Gun safety ☐ Smoke-free house and cars ☐ Preventing sexual abuse

Questions About Your Child

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

Tuberculosis	Was your child born in a country at high risk for tuberculosis (countries other than the United States, Canada, Australia, New Zealand, or Western Europe)?	☐ Yes	☐ No	☐ Unsure
	Has your child traveled (had contact with resident populations) for longer than 1 week to a country at high risk for tuberculosis?	☐ Yes	☐ No	☐ Unsure
	Has a family member or contact had tuberculosis or a positive tuberculin skin test?	☐ Yes	☐ No	☐ Unsure
	Is your child infected with HIV?	☐ Yes	☐ No	☐ Unsure
Dyslipidemia	Does your child have parents or grandparents who have had a stroke or heart problem before age 55?	☐ Yes	☐ No	☐ Unsure
	Does your child have a parent with elevated blood cholesterol (240 mg/dL or higher) or who is taking cholesterol medication?	☐ Yes	☐ No	☐ Unsure
Anemia	Does your child eat a strict vegetarian diet?	☐ Yes	☐ No	☐ Unsure
	If your child is a vegetarian, does your child take an iron supplement?	☐ No	☐ Yes	☐ Unsure
	Does your child's diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?	☐ No	☐ Yes	☐ Unsure

Does your child have any special health care needs? ☐ No ☐ Yes, describe:

Have there been any major changes in your family lately? ☐ Move ☐ Job change ☐ Separation ☐ Divorce ☐ Death in the family ☐ Any other changes?

Does your child live with anyone who uses tobacco or spend time in any place where people smoke? ☐ No ☐ Yes

Your Growing and Developing Child

Do you have concerns about your child's development, learning, or behavior? ☐ No ☐ Yes, describe:

Check off each of the following that are true for your child.

- ☐ Eats healthy meals and snacks
- ☐ Has friends
- ☐ Is doing well in school
- ☐ Participates in an after-school activity
- ☐ Is vigorously active for 1 hour a day
- ☐ Does chores when asked
- ☐ Gets along with friends

Bright Futures™
prevention and health promotion for infants, children, adolescents, and their families™

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Bright Futures Parent Supplemental Questionnaire 7 and 8 Year Visits

For us to provide your child with the best possible health care, we would like to know how things are going.
Please circle Yes or No for each question. Thank you.

School		
Does your child like school?	Yes	No
Is your child involved with school activities?	Yes	No
Does your child get into fights on the playground or elsewhere?	No	Yes

Your Growing Child: Developmental and Mental Health		
Do you let you child know when he is doing a good job?	Yes	No
Do you show affection toward and praise your child?	Yes	No
Do you talk with your child about what happens when she breaks the rules?	Yes	No
Do you feel comfortable answering your child's questions about his changing body simply and honestly?	Yes	No

Staying Healthy: Nutrition and Physical Activity		
Does your child eat at least 5 servings of fruits and vegetables a day?	Yes	No
Does your child drink at least 3 servings of low-fat milk a day or eat yogurt or cheese?	Yes	No
Do you limit foods that are high in fat like candy, soft drinks, salty snacks, or fast food?	Yes	No
Do you eat meals together as a family at least once a week?	Yes	No
Is your child active at least 60 minutes every day?	Yes	No
Does your child watch TV, play video games, or use the computer (not for schoolwork) more than 2 hours a day?	No	Yes
Does your child regularly eat breakfast?	Yes	No

Healthy Teeth: Oral Health		
Does your child brush her teeth twice a day?	Yes	No
Does your child floss once a day?	Yes	No
Does your child visit the dentist twice a year?	Yes	No

Safety

Does your child have reliable after-school care?		Yes	No
Does your child know how to get help in an emergency if you are not there?		Yes	No
Does your child know to dial 911 in an emergency?		Yes	No
Do you know your child's friends and their families?		Yes	No
Have you taught your child that it is never OK for an adult to tell a child to keep secrets from his parents?		Yes	No
Does your child know that is it never OK for an older child or adult to ask to see her private parts?		Yes	No
Does your child always sit in a booster seat in the back seat of the car?		Yes	No
Does your child always wear a helmet and other protective gear when biking, skating, or skiing?		Yes	No
Do you always put sunscreen on your child before he goes outside to play or swim?		Yes	No
Does your child know how to swim and only swim when an adult is watching?		Yes	No
Do you have safety filters installed on your computer?		Yes	No
Do you check your child's Internet history regularly?		Yes	No
Is your family computer in a place you can easily see?	N/A	Yes	No
Does anyone smoke around your child?		No	Yes
Are your cars and home smoke free?		Yes	No
If you smoke, would you like information on how to stop?		Yes	No
Does anyone in your home or the homes where your child spends time have a gun?		No	Yes
If so, are the guns unloaded and locked away with the ammunition locked seperately from the gun?	N/A	Yes	No