PATIENT NAME: _____ **DATE:** _____

Please print.

American Academy of Pediatrics

BRIGHT FUTURES PREVISIT QUESTIONNAIRE
4 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.

- ☐ Go to the bathroom and have a bowel movement by himself.
- ☐ Dress and undress without much help.
- ☐ Play make-believe.
- ☐ Answer questions such as "What do you do when you are cold?" and "When you are sleepy?"
- ☐ Use 4-word sentences.
- ☐ Speak so strangers can understand 100% of what she says.
- ☐ Draw pictures you recognize.
- ☐ Follow simple rules when playing board or card games.
- ☐ Tell you a story from a book.
- ☐ Skip on one foot.
- ☐ Climb stairs, using one foot, then the other, without support.
- ☐ Draw a person with at least 3 body parts.
- ☐ Draw a simple cross.
- ☐ Unbutton and button medium-sized buttons.
- ☐ Grasp a pencil with a thumb and fingers instead of her fist.

PATIENT NAME: _____ **DATE:** _____

Please print.

4 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
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

Living Situation and Food Security		
Is permanent housing a worry for you?	O No	O Yes
Do you 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
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
Safety in the Community		
Do you feel safe in your community?	O Yes	O No
Do you have someone you can turn to if you are concerned about your child's safety?	O Yes	O No
Do you have connections to your community through faith groups, volunteer organizations, or recreational programs?	O Yes	O No
Do you spend time with parents of other children in your community?	O Yes	O No

GETTING READY FOR SCHOOL

Language Understanding and Fluency		
Does your child clearly communicate his wants and needs to you and others?	O Yes	O No
Do you respond to your child's questions with short and simple answers?	O Yes	O No
Do you give your child plenty of time to tell a story or answer a question?	O Yes	O No
Do you talk, sing, and read together every day?	O Yes	O No

PATIENT NAME: _____ **DATE:** _____

Please print.

4 YEAR VISIT

GETTING READY FOR SCHOOL (*CONTINUED*)

Feelings		
Is your child generally happy and active?	○ Yes	○ No
Do you help your child say, "I'm sorry," for hurting others' feelings?	○ Yes	○ No
Opportunities to Socialize With Other Children		
Is your child interested in other children?	○ Yes	○ No
Does your child have a chance to play with other children in playgroups or at preschool?	○ Yes	○ No
Does your child have a best friend?	○ Yes	○ No
Do you praise your child when she is good or has finished a task?	○ Yes	○ No
Early Childhood Programs and Preschool		
Does your child attend preschool?	○ Yes	○ No
Are you happy with your child care or preschool arrangement?	○ Yes	○ No
Do you visit your child's preschool and participate in activities there?	○ Yes	○ No
Readiness for School		
Do you have any concerns about your child starting school in the coming year?	○ No	○ Yes
Are you doing things to get your child ready for preschool? This could include reading together and going to the library, the park, the zoo, and other places.	○ Yes	○ No

HEALTHY HABITS

Nutrition		
Does your child drink water every day?	○ Yes	○ No
How many ounces of milk does your child drink on most days?	_____ oz	
Do you offer your child a variety of foods, including vegetables, fruits, and foods rich in protein, such as meat, eggs, chicken, or fish?	○ Yes	○ No
Is your child willing to try new flavors and food textures?	○ Yes	○ No
Do you let your child decide how much to eat and when to stop?	○ Yes	○ No
Daily Routines That Promote Health		
Does your child sleep well?	○ Yes	○ No
Do you have a regular bedtime and mealtime routines?	○ Yes	○ No
Do you brush your child's teeth twice a day with a pea-sized amount of fluoridated toothpaste?	○ Yes	○ No

LIMITING TV AND PROMOTING PHYSICAL ACTIVITY

How much time every day does your child spend watching TV or using computers, tablets, or smartphones?	_____ hours	
Does your child have a TV or an Internet-connected device in her bedroom?	○ No	○ Yes
Has your family made a media use plan to help everyone balance time spent on media with other family and personal activities?	○ Yes	○ No
Does your child play actively for at least 1 hour a day?	○ Yes	○ No
Does your child play with other children?	○ Yes	○ No
Are you physically active together as a family, such as going for walks or playing in the park?	○ 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

PATIENT NAME: _____ **DATE:** _____

Please print.

4 YEAR VISIT

SAFETY (*CONTINUED*)

Outdoor Safety		
Do you watch your child closely when she plays outside, especially near streets and driveways?	○ Yes	○ No
Are there swimming pools in your neighborhood?	○ No	○ Yes
Are you planning to have your child learn to swim?	○ Yes	○ No
Does your child always wear an US Coast Guard–approved life jacket when on a boat?	○ Yes	○ No
Does your child always use sunscreen when he plays outside?	○ Yes	○ No
Pets		
Do you own a pet?	○ No	○ Yes
Have you taught your child how to behave around animals so she does not get bitten or scratched?	○ Yes	○ No
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

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 | 4 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: _____

Juice: ☐ No ☐ Yes: _____

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: h/d: _____

Source: _____ Quality monitored: ☐ Yes ☐ No

DEVELOPMENT

☑ = Normal development ☐ See Previsit Questionnaire.

Caregiver concerns about development: ☐ None ☐ Yes: _____

☐ SOCIAL LANGUAGE AND SELF-HELP
- Goes to the bathroom and has bowel movement by self
- Dresses and undresses without much help
- Plays make-believe

☐ VERBAL LANGUAGE
- Uses 4-word sentences
- Uses words that are 100% intelligible to strangers
- Answers questions
- Tells a story from a book

☐ GROSS MOTOR
- Climbs stairs, alternating feet without support
- Skips on one foot

☐ FINE MOTOR
- Draws a person with at least 3 body parts
- Draws a simple cross
- Unbuttons and buttons medium-sized buttons
- Grasps a pencil with thumb and fingers instead of fist
- Draws recognizable pictures

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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: _____

Parent-child interaction: Communication: ☐ NL _____ Cooperation: ☐ NL _____

Choices: ☐ NL _____ Appropriate responses to behavior: ☐ NL _____

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

Preschool: ☐ 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:** Well-appearing child. **Normal interval growth. Normal BMI and BP for age.** _____

☐ Head: Normocephalic and atraumatic. _____

☐ **Eyes: 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 visible decay **or white spots. No 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. Speech clear and fluent without articulation difficulties. 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**
- Living situation and food security
- Tobacco, alcohol, and drug use
- Intimate partner violence
- Safety in the community
- Engagement in the community

☐ **DEVELOPING HEALTHY NUTRITION AND PERSONAL HABITS**
- Water, milk, and juice
- Nutritious foods
- Daily routines that promote health

☐ **SCHOOL READINESS**
- Language understanding and fluency
- Feelings
- Opportunities to socialize with other children
- Readiness for structured learning experiences
- Early childhood programs and preschool

☐ **MEDIA USE**
- Limits on use
- Promoting physical activity and safe play

☐ **SAFETY**
- Belt-positioning car booster seats
- Outdoor safety
- Water safety
- Sun protection
- Pets
- 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 ☐ Dyslipidemia ☐ Lead ☐ Oral health ☐ Tuberculosis

Comments/results:

Follow-up:

☐ Routine follow-up at 5 years ☐ Next visit: _____ ☐ Referral to: _____

PRINT NAME.	SIGNATURE
Provider 1	
Provider 2	

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BRIGHT FUTURES HANDOUT ▶ **PARENT**

4 YEAR VISIT

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

HOW YOUR FAMILY IS DOING

- Stay involved in your community. Join activities when you can.
- If you are worried about your living or food situation, talk with us. Community agencies and programs such as WIC and 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 feel unsafe in your home or have been hurt by someone, let us know. Hotlines and community agencies can also provide confidential help.
- Teach your child about how to be safe in the community.
  - Use correct terms for all body parts as your child becomes interested in how boys and girls differ.
  - 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.

GETTING READY FOR SCHOOL

- Give your child plenty of time to finish sentences.
- Read books together each day and ask your child questions about the stories.
- Take your child to the library and let him choose books.
- Listen to and treat your child with respect. Insist that others do so as well.
- Model saying you're sorry and help your child to do so if he hurts someone's feelings.
- Praise your child for being kind to others.
- Help your child express his feelings.
- Give your child the chance to play with others often.
- Visit your child's preschool or child care program. Get involved.
- Ask your child to tell you about his day, friends, and activities.

HEALTHY HABITS

- Give your child 16 to 24 oz of milk every day.
- Limit juice. It is not necessary. If you choose to serve juice, give no more than 4 oz a day of 100% juice and always serve it with a meal.
- Let your child have cool water when she is thirsty.
- Offer a variety of healthy foods and snacks, especially vegetables, fruits, and lean protein.
- Let your child decide how much to eat.
- Have relaxed family meals without TV.
- Create a calm bedtime routine.
- Have your child brush her teeth twice each day. Use a pea-sized amount of toothpaste with fluoride.

TV AND MEDIA

- Be active together as a family often.
- Limit TV, tablet, or smartphone use to no more than 1 hour of high-quality programs each day.
- Discuss the programs you watch together as a family.
- Consider making a family media plan. It helps you make rules for media use and balance screen time with other activities, including exercise.
- Don't put a TV, computer, tablet, or smartphone in your child's bedroom.
- Create opportunities for daily play.
- Praise your child for being active.

Helpful Resources: National Domestic Violence Hotline: 800-799-7233 | 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

4 YEAR VISIT—PARENT

SAFETY

- Use a forward-facing car safety seat or switch to a belt-positioning booster seat when your child reaches the weight or height limit for her car safety seat, her shoulders are above the top harness slots, or her ears come to the top of the car safety seat.
- The back seat is the safest place for children to ride until they are 13 years old.
- Make sure your child learns to swim and always wears a life jacket. Be sure swimming pools are fenced.
- When you go out, put a hat on your child, have her wear sun protection clothing, and apply sunscreen with SPF of 15 or higher on her exposed skin. Limit time outside when the sun is strongest (11:00 am–3:00 pm).
- If it is necessary to keep a gun in your home, store it unloaded and locked with the ammunition locked separately.
- Ask if there are guns in homes where your child plays. If so, make sure they are stored safely.

WHAT TO EXPECT AT YOUR CHILD'S 5 AND 6 YEAR VISIT

We will talk about

- Taking care of your child, your family, and yourself
- Creating family routines and dealing with anger and feelings
- Preparing for school
- Keeping your child's teeth healthy, eating healthy foods, and staying active
- Keeping your child safe at home, outside, and in the car

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