Bright Futures Parent Supplemental Questionnaire 15 Month Visit

For us to provide you and 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.

Talking and Feeling: Communication and Social Development

Do you help your child feel comfortable around new people?	Yes	No
Do you talk with others about parenting issues?	Yes	No
Do you take time for yourself?	Yes	No
Do you spend time alone with your partner?	Yes	No
Do you talk to, sing to, and look at books with your child every day?	Yes	No
Can your child tell you what she wants by pulling and pointing?	Yes	No
Does your child play actively for one hour or more a day?	Yes	No
Are you worried about your child's weight?	No	Yes
How many hours per day does your child watch TV?	_____ hours	

A Good Night's Sleep: Sleep Routines and Issues

Does your child have a regular bedtime routine?	Yes	No
Do you let your child fall asleep on his own?	Yes	No
Does your child have a blanket, stuffed animal, or toy that she likes to sleep with?	Yes	No

Temper Tantrums and Discipline

If your child is upset, do you help change his focus to another activity, book, or toy?	Yes	No
Do you set limits for your child?	Yes	No
Do you and other caregivers set the same limits for your child?	Yes	No
Do you teach your child the right way to act?	Yes	No
Do you praise your child when she is being good?	Yes	No

Healthy Teeth

Has your child been to a dentist?	Yes	No
Do you brush your child's teeth with water 2 times a day, using a soft toothbrush?	Yes	No
Does your child use a bottle?	No	Yes
Does your child use a bottle in bed?	No	Yes

Safety

Do you always use a car safety seat in the back seat of the car?	Yes	No
Are you having any problems with your car safety seat?	No	Yes
Do you keep cleaners and medicines locked up?	Yes	No
Do you have the number for poison control near every telephone?	Yes	No
Do you keep cigarettes, lighters, matches, and alcohol out of your child's sight and reach?	Yes	No
Does anyone smoke around your child?	No	Yes
If you smoke, would you like information on how to stop?	Yes	No
Do you keep your child away from the stove?	Yes	No
Do you have a working smoke and carbon monoxide detector on every floor of your home?	Yes	No
Do you have a fire escape plan?	Yes	No
Do you know if the temperature of your hot water heater is below 120°F?	Yes	No

Bright Futures Medical Screening Questionnaire
15 Month Visit

Please answer the following questions about your child's health by circling Y, N, or Unsure.

Do you have concerns about how your child hears?	Y	N	Unsure
Do you have concerns about how your child speaks?	Y	N	Unsure
Do you have concerns about how your child sees?	Y	N	Unsure
Have your child's eyes ever been injured?	Y	N	Unsure
Does your child hold objects close when trying to focus?	Y	N	Unsure
Do your child's eyes appear unusual or seem to cross, drift, or be lazy?	Y	N	Unsure
Do your child's eyelids droop or does one eyelid tend to close?	Y	N	Unsure

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

American Academy of Pediatrics
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