Bright Futures Parent Supplemental Questionnaire 18 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.

Your Child and Family: Family Support

Do you take time for yourself?	Yes	No
Do you do activities as a family like playing together and eating meals together?	Yes	No
Do you know about community resources like WIC, Head Start, and food stamps?	Yes	No
Has your partner ever hurt you or your child?	No	Yes
Do you teach your child that behaviors like biting and hitting are not OK?	Yes	No
Does your child taste and try to eat new foods?	Yes	No
Are you considering having another child?	No	Yes
Do you have enough food for your family?	Yes	No

Your Child's Behavior: Child Development and Behavior

Do you play with and read to your child every day?	Yes	No
Do you praise your child for good behavior?	Yes	No
If your child is upset, do you help change his focus to another activity, book, or toy?	Yes	No
Do you talk to others about how to raise your child?	Yes	No
Do you and other caregivers set the same limits for your child?	Yes	No
How many hours per day does your child watch TV?	______	hours
Does your child play actively for at least one hour per day?	Yes	No

Talking and Hearing: Language Promotion/Hearing

Does your child point to what she wants, call some things by name, and wave bye-bye?	Yes	No
Do you read, sing, and talk with your child about what you are seeing and doing?	Yes	No
Do you use simple words to tell your child what to do?	Yes	No

Toilet Training: Toilet-training Readiness

Does your child show signs that he is ready to start toilet training?

Can stay dry for 2 hours	Yes	No
Knowing when he is wet and dry	Yes	No
Saying when he is about to have a bowel movement	Yes	No
Can pull his pants up and down	Yes	No
Do you read books with your child about using the potty?	Yes	No
Does your child go to the bathroom with a parent, brother, or sister to learn what to do?	Yes	No

Safety

Do you always use a car safety seat in the back seat of all vehicles?		Yes	No
Are you having any problems with your car safety seat?		No	Yes
Does everyone in the car always use a seat belt?		Yes	No
Do you have smoke and carbon monoxide detectors on each floor of your home?		Yes	No
In case of a fire, do you have a plan for getting everyone out of the house and a meeting place outside?		Yes	No
Do you know the telephone number for poison control?		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 cigarettes, lighters, matches, and alcohol out of your child's sight and reach?		Yes	No
Do you keep your child away from the stove?		Yes	No
Do you have a gate on your stairs?		Yes	No
Do you keep furniture away from windows and use window guards for second floor and higher windows?		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?	N/A	Yes	No

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Bright Futures Medical Screening Questionnaire 18 Month Visit

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

Question			
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
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
Have your child's eyes ever been injured?	Y	N	Unsure
Does your child have a sibling or playmate who has or had lead poisoning?	Y	N	Unsure
Does your child live in or regularly visit a house or child care facility built before 1978 that is being or has recently been (within the last 6 months) renovated or remodeled?	Y	N	Unsure
Does your child live in or regularly visit a house or child care facility built before 1950?	Y	N	Unsure
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)?	Y	N	Unsure
Has your child traveled (had contact with resident populations) for longer than 1 week to a country at high risk for tuberculosis?	Y	N	Unsure
Has a family member or contact had tuberculosis or a positive tuberculin skin test?	Y	N	Unsure
Is your child infected with HIV?	Y	N	Unsure
Do you ever struggle to put food on the table?	Y	N	Unsure
Does your child's diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?	N	Y	Unsure
Does your child have a dentist?	N	Y	Unsure
Does your child's primary water source contain fluoride?	N	Y	Unsure

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