

PATIENT NAME: _____ DATE: _____

Please print.

American Academy of Pediatrics

DATE OF BIRTH: _____



BRIGHT FUTURES PREVISIT QUESTIONNAIRE

1 MONTH VISIT

To provide you and your baby with the best possible health care, we would like to know how things are going. Please answer all the questions. **Maternal Depression screening is also part of this visit.** 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 BABY AND FAMILY.

What excites or delights you most about your baby?

Does your baby have special health care needs? No Yes, describe:

Have there been major changes lately in your baby's or family's life? No Yes, describe:

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

Does your baby live with anyone who smokes or spend time in places where people smoke or use e-cigarettes? No Yes Unsure

YOUR GROWING AND DEVELOPING BABY

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

Check off each of the tasks that your baby is able to do.

- | | | |
|---|--|--|
| <input type="checkbox"/> Look at you. | <input type="checkbox"/> Make short sounds such as "ooh" and "ah." | <input type="checkbox"/> Use different cries for hunger and tiredness. |
| <input type="checkbox"/> Follow you with her eyes. | <input type="checkbox"/> Become alert when she hears unexpected sounds. | <input type="checkbox"/> Move both arms and legs together. |
| <input type="checkbox"/> Comfort himself by doing things such as bringing his hands to his mouth. | <input type="checkbox"/> Become quiet or turn when he hears your voice. | <input type="checkbox"/> Hold his chin up when he is on his stomach. |
| <input type="checkbox"/> Start to get fussy when she is bored. | <input type="checkbox"/> Show signs she is sensitive to her surroundings (such as crying or startling) or need extra support to handle daily activities. | <input type="checkbox"/> Open her fingers a little when at rest. |
| <input type="checkbox"/> Calm when he is picked up or spoken to. | | |
| <input type="checkbox"/> Look briefly at objects. | | |

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RISK ASSESSMENT

Tuberculosis	Was your baby 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)?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Has your baby had close contact with a person who has tuberculosis disease or who has had a positive tuberculosis test result?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Is your baby infected with HIV?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
Vision	Do you have concerns about how your baby sees?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure

ANTICIPATORY GUIDANCE

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

YOUR FAMILY'S HEALTH AND WELL-BEING

Living Situation and Food Security				
Is permanent housing a worry for you?		<input type="radio"/> No	<input type="radio"/> Yes	
Do you have the things you need to take care of your baby, such as a crib, a car safety seat, and diapers?		<input type="radio"/> Yes	<input type="radio"/> No	
Does your home have enough heat, hot water, and electricity?		<input type="radio"/> Yes	<input type="radio"/> No	
Do you have health insurance for yourself?		<input type="radio"/> Yes	<input type="radio"/> No	
Within the past 12 months, were you ever worried whether your food would run out before you got money to buy more?		<input type="radio"/> No	<input type="radio"/> Yes	
Within the past 12 months, did the food you bought not last, and you did not have money to get more?		<input type="radio"/> No	<input type="radio"/> Yes	
Do you need help in finding community support services, such as WIC or food stamps?		<input type="radio"/> No	<input type="radio"/> Yes	
Have you had any problems with mold or dampness in your home?		<input type="radio"/> No	<input type="radio"/> Yes	
If your home has a basement, has it been checked for radon?		<input type="radio"/> NA	<input type="radio"/> Yes	<input type="radio"/> No
Do you use pesticides inside or outside your home?		<input type="radio"/> No	<input type="radio"/> Yes	
Intimate Partner Violence				
Do you always feel safe in your home?		<input type="radio"/> Yes	<input type="radio"/> No	
Has your partner, or another significant person in your life, ever hit, kicked, or shoved you, or physically hurt you or the baby?		<input type="radio"/> No	<input type="radio"/> Yes	
Maternal Alcohol and Substance Use				
Does anyone in your household drink beer, wine, or liquor?		<input type="radio"/> No	<input type="radio"/> Yes	
Do you or other family members use marijuana, cocaine, pain pills, narcotics, or other controlled substances?		<input type="radio"/> No	<input type="radio"/> Yes	
Family Support				
Do you feel comfortable returning to work or school after the baby's birth?		<input type="radio"/> Yes	<input type="radio"/> No	
Have you made arrangements for child care?		<input type="radio"/> Yes	<input type="radio"/> No	

MOTHER'S HEALTH AND FAMILY RELATIONSHIPS

Have you had a post-birth checkup?		<input type="radio"/> Yes	<input type="radio"/> No	
Does your partner or do other family members help care for the baby and help around the house?		<input type="radio"/> Yes	<input type="radio"/> No	
If you have older children, are they getting along with the baby?		<input type="radio"/> NA	<input type="radio"/> Yes	<input type="radio"/> No

CARING FOR YOUR BABY

Is your baby sleeping well?		<input type="radio"/> Yes	<input type="radio"/> No	
Does your baby use a pacifier?		<input type="radio"/> Yes	<input type="radio"/> No	
Can you tell what your baby wants by how she cries?		<input type="radio"/> Yes	<input type="radio"/> No	
Are you able to calm your baby?		<input type="radio"/> Yes	<input type="radio"/> No	
Is a TV, computer, tablet, or smartphone on in the background while your baby is in the room?		<input type="radio"/> No	<input type="radio"/> Yes	
Do you put your baby on his tummy for short periods of time when he is awake and with you?		<input type="radio"/> Yes	<input type="radio"/> No	

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CARING FOR YOUR BABY (CONTINUED)

Medical Home After-hours Support		
Do you know how to take your baby's temperature rectally?	<input type="radio"/> Yes	<input type="radio"/> No
Do you know when to call your baby's doctor?	<input type="radio"/> Yes	<input type="radio"/> No
General Information		
Does your baby feed well?	<input type="radio"/> Yes	<input type="radio"/> No
Do you give your baby any supplements, herbs, special teas, or vitamins?	<input type="radio"/> No	<input type="radio"/> Yes
Can you tell when your baby is hungry?	<input type="radio"/> Yes	<input type="radio"/> No
Can you tell when your baby is full?	<input type="radio"/> Yes	<input type="radio"/> No
Do you ever prop the bottle rather than holding it or put your baby to bed with a bottle?	<input type="radio"/> No	<input type="radio"/> Yes
Are you able to burp your baby?	<input type="radio"/> Yes	<input type="radio"/> No
If you are breastfeeding, answer these questions.		
Is breastfeeding uncomfortable or painful?	<input type="radio"/> No	<input type="radio"/> Yes
Do you eat foods high in protein (such as eggs, lean meat, poultry, fish, or beans) every day?	<input type="radio"/> Yes	<input type="radio"/> No
Are you continuing to take prenatal vitamins?	<input type="radio"/> Yes	<input type="radio"/> No
Do you take medications (either over-the-counter or prescription) or herbal supplements?	<input type="radio"/> No	<input type="radio"/> Yes
Are you giving your baby vitamin D drops?	<input type="radio"/> Yes	<input type="radio"/> No
If you are formula feeding, or providing formula supplementation, answer these questions.		
Are you using iron-fortified formula?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have any questions about using formula, such as how much it costs or how to prepare it?	<input type="radio"/> No	<input type="radio"/> Yes

SAFETY

Car and Home Safety		
Is your baby fastened securely in a rear-facing car safety seat in the back seat every time she rides in a vehicle?	<input type="radio"/> Yes	<input type="radio"/> No
Are you having any problems with your car safety seat?	<input type="radio"/> No	<input type="radio"/> Yes
Do you always keep one hand on your baby when changing diapers or clothing on a changing table, couch, or bed?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have emergency phone numbers near every telephone and in your cell phone for rapid dial?	<input type="radio"/> Yes	<input type="radio"/> No
Safe Sleep		
Does your baby sleep on his back?	<input type="radio"/> Yes	<input type="radio"/> No
Does your baby sleep in a crib?	<input type="radio"/> Yes	<input type="radio"/> No
Does your baby sleep in your room?	<input type="radio"/> Yes	<input type="radio"/> 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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The information contained in this questionnaire should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances. Original questionnaire included as part of the *Bright Futures Tool and Resource Kit, 2nd Edition*.

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