CLEAR FORM

PATIENT NAME: _____ DATE: _____

Please print.

American Academy of Pediatrics

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.

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

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1 MONTH VISIT

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)?	O No	O Yes	O Unsure
	Has your baby 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 baby infected with HIV?	O No	O Yes	O Unsure
Vision	Do you have concerns about how your baby sees?	O No	O Yes	O 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?		O No	O Yes
Do you have the things you need to take care of your baby, such as a crib, a car safety seat, and diapers?		O Yes	O No
Does your home have enough heat, hot water, and electricity?		O Yes	O No
Do you have health insurance for yourself?		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
Do you need help in finding community support services, such as WIC or food stamps?		O No	O Yes
Have you had any problems with mold or dampness in your home?		O No	O Yes
If your home has a basement, has it been checked for radon?	O NA	O Yes	O No
Do you use pesticides inside or outside your home?		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 the baby?		O No	O Yes
Maternal Alcohol and Substance Use			
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
Family Support			
Do you feel comfortable returning to work or school after the baby's birth?		O Yes	O No
Have you made arrangements for child care?		O Yes	O No

MOTHER'S HEALTH AND FAMILY RELATIONSHIPS

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

CARING FOR YOUR BABY

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

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1 MONTH VISIT

CARING FOR YOUR BABY (*CONTINUED*)

Medical Home After-hours Support		
Do you know how to take your baby's temperature rectally?	O Yes	O No
Do you know when to call your baby's doctor?	O Yes	O No
General Information		
Does your baby feed well?	O Yes	O No
Do you give your baby any supplements, herbs, special teas, or vitamins?	O No	O Yes
Can you tell when your baby is hungry?	O Yes	O No
Can you tell when your baby is full?	O Yes	O No
Do you ever prop the bottle rather than holding it or put your baby to bed with a bottle?	O No	O Yes
Are you able to burp your baby?	O Yes	O No
If you are breastfeeding, answer these questions.		
Is breastfeeding uncomfortable or painful?	O No	O Yes
Do you eat foods high in protein (such as eggs, lean meat, poultry, fish, or beans) every day?	O Yes	O No
Are you continuing to take prenatal vitamins?	O Yes	O No
Do you take medications (either over-the-counter or prescription) or herbal supplements?	O No	O Yes
Are you giving your baby vitamin D drops?	O Yes	O No
If you are formula feeding, or providing formula supplementation, answer these questions.		
Are you using iron-fortified formula?	O Yes	O No
Do you have any questions about using formula, such as how much it costs or how to prepare it?	O No	O 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?	O Yes	O No
Are you having any problems with your car safety seat?	O No	O Yes
Do you always keep one hand on your baby when changing diapers or clothing on a changing table, couch, or bed?	O Yes	O No
Do you have emergency phone numbers near every telephone and in your cell phone for rapid dial?	O Yes	O No
Safe Sleep		
Does your baby sleep on his back?	O Yes	O No
Does your baby sleep in a crib?	O Yes	O No
Does your baby sleep in your room?	O Yes	O 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.

American Academy of Pediatrics

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