

PATIENT NAME: _____ DATE: _____

Please print.

American Academy of Pediatrics

BRIGHT FUTURES PREVISIT QUESTIONNAIRE

2 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"/> Smile back at you. | <input type="checkbox"/> Make short cooing sounds. | <input type="checkbox"/> Hold her chin up when she is on her stomach. |
| <input type="checkbox"/> Make sounds that let you know he is happy or upset. | <input type="checkbox"/> Move both arms and legs together. | <input type="checkbox"/> Open and shut his hands. |

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RISK ASSESSMENT

Vision	Do you have concerns about how your baby sees?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
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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
Family Support			
Are you getting enough rest?		<input type="radio"/> Yes	<input type="radio"/> No
Have you been out of the house without your baby (such as to the store, to restaurants, or on a walk)?		<input type="radio"/> Yes	<input type="radio"/> No
Have you found someone to care for your baby when you return to work or school?		<input type="radio"/> Yes	<input type="radio"/> No
If yes, are you comfortable with these arrangements?		<input type="radio"/> NA	<input type="radio"/> Yes <input type="radio"/> No

HOW YOU ARE FEELING

Have you had your 6-week after-birth checkup?		<input type="radio"/> Yes	<input type="radio"/> No
If you have other children, are you able to spend time with them?		<input type="radio"/> NA	<input type="radio"/> Yes <input type="radio"/> No

CARING FOR YOUR BABY

Your Growing Baby			
Do you enjoy taking care of your baby?		<input type="radio"/> Yes	<input type="radio"/> No
Do you and your baby "talk" together during your daily routines?		<input type="radio"/> Yes	<input type="radio"/> No
Are you comfortable and confident in your abilities as a parent?		<input type="radio"/> Yes	<input type="radio"/> No
Is your baby beginning to develop regular sleep patterns?		<input type="radio"/> Yes	<input type="radio"/> No
Is a TV, computer, tablet, or smartphone on in the background when your baby is in the room?		<input type="radio"/> No	<input type="radio"/> Yes
Do you put your baby on her tummy for short periods of time when she is awake and with you?		<input type="radio"/> Yes	<input type="radio"/> No
Do you have ways to calm your baby when he is crying?		<input type="radio"/> Yes	<input type="radio"/> No
Are you ever afraid that you or other caregivers may hurt the baby?		<input type="radio"/> No	<input type="radio"/> Yes

FEEDING YOUR BABY

General Information			
Do you have any questions about feeding your baby?		<input type="radio"/> No	<input type="radio"/> Yes
Are you feeding your baby anything other than breast milk or formula?		<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

2 MONTH VISIT

FEEDING YOUR BABY (CONTINUED)

If you are breastfeeding, answer these questions.

Are you giving your baby vitamin D drops?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have questions about pumping and storing your breast milk?	<input type="radio"/> No	<input type="radio"/> Yes

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 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 using your car safety seat?	<input type="radio"/> No	<input type="radio"/> Yes
Is your water heater set so the temperature at the faucet is at or below 120°F/49°C?	<input type="radio"/> Yes	<input type="radio"/> No
Do you always stay within arm's reach whenever your baby is in or near water?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have any questions about things you can do to keep your baby safe at home?	<input type="radio"/> No	<input type="radio"/> Yes

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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DEDICATED TO THE HEALTH OF ALL CHILDREN®



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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