Patient:_____ Date:_____ MRN:_____

Bright Futures Previsit Questionnaire
1 Month Visit

For us to provide you and your baby with the best possible health care, we would like to know how things are going.
Please answer all of the questions. 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?

_____

We are interested in answering your questions. Please check off the boxes for the topics you would like to discuss the most today.

How You Are Feeling	☐ Feeling sad ☐ Using drugs ☐ Using alcohol ☐ Smoking ☐ Getting back to work or school ☐ Breastfeeding plans ☐ Choosing child care
Your Baby and Family	☐ Asking for help when you need it ☐ Community services that may be able to help your family ☐ Violence at home/abuse
Getting to Know Your Baby	☐ Sleep/wake schedules ☐ Where your baby sleeps ☐ How your baby sleeps ☐ How to keep your baby safe while sleeping ☐ Bored baby ☐ Tummy time for playtime with you ☐ How to calm your baby ☐ Crying too much
Feeding Your Baby	☐ How often you should feed your baby ☐ How to know your baby is getting enough ☐ What to feed your baby ☐ Formula feeding ☐ Help with breastfeeding ☐ How to hold your baby while feeding ☐ Burping ☐ Using a pacifier ☐ Worry about your baby's weight
Safety	☐ Car safety seats ☐ Preventing falls ☐ Choking from bracelets, necklaces, and toys with loops or strings

Questions About Your Baby

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

_____

Vision	Do you have concerns about how your child sees?	☐ Yes	☐ No	☐ Unsure
Tuberculosis	Has a family member or contact had tuberculosis or a positive tuberculin skin test?	☐ Yes	☐ No	☐ Unsure
	Was your child born in a country at high risk for tuberculosis (countries other than the United Sates, Canada, Australia, New Zealand, and Western Europe)?	☐ Yes	☐ No	☐ Unsure
	Has your child traveled (had contact with resident populations) for longer than 1 week to a country at high risk for tuberculosis?	☐ Yes	☐ No	☐ Unsure

Does your child have any special health care needs? ☐ No ☐ Yes, describe:

_____

Other than your baby's birth, have there been any major changes in your family lately?
☐ Move ☐ Job change ☐ Separation ☐ Divorce ☐ Death in the family ☐ Any other changes? Describe:

_____

Over the past 2 weeks, how often have you been bothered by any of the following problems?
1. Little interest or pleasure in doing things ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
2. Feeling down, depressed, or hopeless ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Does your child live with anyone who uses tobacco or spend time in any place where people smoke? ☐ No ☐ Yes

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.
☐ If upset, able to calm ☐ Recognizes parents' voices ☐ Lifts head when on tummy
☐ Follows parents with eyes ☐ Smiles

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

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™