



# BRIGHT FUTURES PREVISIT QUESTIONNAIRE

## 9 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. **Child Development screening and Oral Health Risk Assessment are 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"/> Use basic gestures, such as holding her arms out to be picked up or waving "bye-bye." | <input type="checkbox"/> Look around when you say things such as "Where's your bottle?" and "Where's your blanket?" | <input type="checkbox"/> Crawl on hands and knees.                         |
| <input type="checkbox"/> Look for dropped objects.   | <input type="checkbox"/> Copy sounds that you make.   | <input type="checkbox"/> Pick up food and eat it.                          |
| <input type="checkbox"/> Play games such as peekaboo and pat-a-cake.   | <input type="checkbox"/> Sit well without support.  | <input type="checkbox"/> Pick up small objects with 3 fingers and a thumb. |
| <input type="checkbox"/> Turn consistently when his name is called.  | <input type="checkbox"/> Pull herself to a standing position.   | <input type="checkbox"/> Let go of objects on purpose.                     |
| <input type="checkbox"/> Say, "Dada" or "Mama."  | <input type="checkbox"/> Move easily between sitting and lying.   | <input type="checkbox"/> Bang objects together.                            |

## 9 MONTH VISIT

### RISK ASSESSMENT

<b>Hearing</b>	Do you have concerns about how your baby hears?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
<b>Lead</b>	Does your baby live in or visit a home or child care facility with an identified lead hazard or a home built before 1960 that is in poor repair or that was renovated in the past 6 months?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
<b>Oral health</b>	Does your baby's primary water source contain fluoride?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unsure
<b>Vision</b>	Do you have concerns about how your baby sees?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Do your baby's eyes appear unusual or seem to cross?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Do your baby's eyelids droop or does one eyelid tend to close?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Have your baby's eyes ever been injured?	<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

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
Have you developed routines or other ways to take care of yourself?	<input type="radio"/> Yes	<input type="radio"/> No

#### CARING FOR YOUR BABY

Do you have a regular bedtime routine for your baby?	<input type="radio"/> Yes	<input type="radio"/> No
Does she wake up during the night?	<input type="radio"/> No	<input type="radio"/> Yes
Is your baby learning new things?	<input type="radio"/> Yes	<input type="radio"/> No
Does your baby have ways to tell you what he wants and needs?	<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
Does your baby watch TV or play on a tablet or smartphone? If yes, how much time each day? _____ hours	<input type="radio"/> No	<input type="radio"/> Yes
Have you made a family media use plan to help you balance media use with other family activities?	<input type="radio"/> Yes	<input type="radio"/> No

#### DISCIPLINE

Do you and your partner agree on how to handle your baby's behavior?	<input type="radio"/> Yes	<input type="radio"/> No
Do you limit the use of "No" to only the most important issues?	<input type="radio"/> Yes	<input type="radio"/> No
If you have other children, do you let them help with the baby as much as they can?	<input type="radio"/> NA	<input type="radio"/> Yes <input type="radio"/> No

#### FEEDING YOUR BABY

Does your baby feed herself?	<input type="radio"/> Yes	<input type="radio"/> No
Does your baby drink from a cup?	<input type="radio"/> Yes	<input type="radio"/> No
Do you let your baby decide what and how much to eat?	<input type="radio"/> Yes	<input type="radio"/> No
Do you give your baby foods with different textures (such as pureed, blended, mashed, chopped, or lumps)?	<input type="radio"/> Yes	<input type="radio"/> No
If you are breastfeeding, are you planning on continuing?	<input type="radio"/> NA	<input type="radio"/> Yes <input type="radio"/> No

#### SAFETY

<b>Car and Home Safety</b>		
Is your baby fastened securely in a rear-facing car safety seat in the back seat every time he rides in a vehicle?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have any habits or reminders that prevent you from ever leaving your baby in the car?	<input type="radio"/> Yes	<input type="radio"/> No
Do you keep your baby away from the stove, fireplaces, and space heaters?	<input type="radio"/> Yes	<input type="radio"/> No

Please print.

## 9 MONTH VISIT

### SAFETY (CONTINUED)

Car and Home Safety (continued)		
Do you keep cleaners and medicines locked up and out of your baby's sight and reach?	<input type="radio"/> Yes	<input type="radio"/> No
Do you always stay within arm's reach of your baby when she is in the bathtub?	<input type="radio"/> Yes	<input type="radio"/> No
Do you keep furniture away from windows and use operable window guards on second-floor and higher windows? (Operable means that, in case of an emergency, an adult can open the window.)	<input type="radio"/> Yes	<input type="radio"/> No
Do you have a gate at the top and bottom of all stairs in your home?	<input type="radio"/> Yes	<input type="radio"/> No
Gun Safety		
Does anyone in your home or the homes where your baby spends time have a gun?	<input type="radio"/> No	<input type="radio"/> Yes
If yes, is the gun unloaded and locked up?	<input type="radio"/> Yes	<input type="radio"/> No
If yes, is the ammunition stored and locked up separately from the gun?	<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>.

American Academy of Pediatrics

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