

American Academy of Pediatrics



BRIGHT FUTURES PREVISIT QUESTIONNAIRE

FIRST WEEK VISIT (3 TO 5 DAYS)

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. 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 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"/> Stay awake for a short time to feed. | <input type="checkbox"/> Calm to an adult's voice. | <input type="checkbox"/> Move her arms and legs at the same time when startled. |
| <input type="checkbox"/> Make brief eye contact with an adult when held. | <input type="checkbox"/> Lift and turn his head to the side briefly when he is on his tummy. | <input type="checkbox"/> Keep his hands in a fist. |
| <input type="checkbox"/> Cry when she is uncomfortable. | | |

FIRST WEEK VISIT (3 TO 5 DAYS)

RISK ASSESSMENT

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	
Family Support			
Do you search the Internet to learn about how to care for your baby?	<input type="radio"/> No	<input type="radio"/> Yes	

GETTING TO KNOW YOUR BABY

How You Are Feeling			
Do you sleep when the baby sleeps?	<input type="radio"/> Yes	<input type="radio"/> No	
Does your partner or do other family members help with the baby?	<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

Do you read to your baby?	<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	
Is your baby able to fully awaken for feedings?	<input type="radio"/> Yes	<input type="radio"/> No	
Do you have questions about how to calm your baby?	<input type="radio"/> No	<input type="radio"/> Yes	
When to Call Your Doctor/Emergency Planning			
Do you know how to take your baby's temperature rectally?	<input type="radio"/> Yes	<input type="radio"/> No	
Do you have a list of emergency phone numbers?	<input type="radio"/> Yes	<input type="radio"/> No	
Do you have any questions about taking your baby out in public places?	<input type="radio"/> No	<input type="radio"/> Yes	

FEEDING YOUR BABY

General Information			
Does your baby feed well?	<input type="radio"/> Yes	<input type="radio"/> No	
Do you have any questions about how your baby is growing?	<input type="radio"/> No	<input type="radio"/> Yes	
Are you having problems burping your baby?	<input type="radio"/> Yes	<input type="radio"/> No	
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	
Does your baby have 5 or 6 wet disposable diapers (or 6–8 cloth diapers) and 3 or 4 stools a day?	<input type="radio"/> Yes	<input type="radio"/> No	

Please print.

FIRST WEEK VISIT (3 TO 5 DAYS)

FEEDING YOUR BABY (CONTINUED)

If you are breastfeeding, answer these questions.		
Is breastfeeding uncomfortable or painful?	<input type="radio"/> No	<input type="radio"/> Yes
Do you eat foods that are 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
Have you started developing habits that will help prevent you from ever forgetting your baby in the car?	<input type="radio"/> Yes	<input type="radio"/> No
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
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>.

American Academy of Pediatrics

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.

The American Academy of Pediatrics (AAP) does not review or endorse any modifications made to this questionnaire and in no event shall the AAP be liable for any such changes.

© 2019 American Academy of Pediatrics. All rights reserved.