Bright Futures Parent Supplemental 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 circle Yes or No for each question. Thank you.

How You Are Feeling: Parental Well-being

Do you still have pain from the delivery?	No	Yes
Are you happy in your relationships with your partner, family, and friends?	Yes	No

Your Baby and Family: Family Adjustment

Are you happy with your baby?		Yes	No
Do you feel comfortable caring for your baby?		Yes	No
Do you have enough money for food, clothing, diapers, and child care?		Yes	No
Are you able to pay for housing?		Yes	No
Does your partner help care for the baby and help around the house?		Yes	No
Do you ever feel afraid of your partner?		No	Yes
Do you have people you can call if you are feeling frustrated?		No	Yes
If you have older children, are they getting along with the baby?	N/A	Yes	No
Are you able to spend time alone with your older children?	N/A	Yes	No
How many hours per day does your baby watch TV?		_____ hours	

Getting to Know Your Baby: Infant Adjustment

Does your baby sleep on his back?	Yes	No
Does your baby sleep in a crib in your room?	Yes	No
Can you tell what your baby wants by how she cries?	Yes	No
Are you able to calm your baby?	Yes	No
Does your baby spend time with you on his tummy when awake?	Yes	No
Do you play and talk with your baby when she is awake?	Yes	No
Do you and your baby have a sleep/wake schedule?	Yes	No
Does your baby use a pacifier?	Yes	No

Feeding Your Baby: Feeding Routines

Do you have any breast pain or pain from breastfeeding?	No	Yes
Can you tell when your baby is hungry?	Yes	No
Can you tell when your baby is full?	Yes	No
Do you ever prop the bottle or put your baby to bed with a bottle?	No	Yes
Is your baby having at least 6–8 wet diapers each day?	Yes	No
Are you able to burp your baby?	Yes	No

Safety

Do you always use a car safety seat?	Yes	No
Is your baby's car safety seat always rear-facing in the back seat of the car?	Yes	No
Are you having any problems with your car safety seat?	No	Yes
Are your home and car smoke free?	Yes	No
Does anyone smoke around your child?	No	Yes
If you smoke, would you like information on how to stop?	Yes	No
Do you always feel that you and your baby are safe in your home?	Yes	No
Do you always keep one hand on your baby when changing him on a changing table or couch?	Yes	No
Do you have a list of emergency numbers?	Yes	No
Do you know how to take your baby's temperature rectally?	Yes	No
Do you know when to call your baby's doctor?	Yes	No
Does your baby wear a pacifier or jewelry around her neck?	No	Yes

Bright Futures Medical Screening Questionnaire
1 Month Visit

Please answer the following questions about your child's health by circling Y, N, or Unsure.

Do you have concerns about how your child sees?	Y	N	Unsure
Has a family member or contact had tuberculosis or a positive tuberculin skin test?	Y	N	Unsure
Was your child born in a country at high risk for tuberculosis (countries other than the United States, Canada, Australia, New Zealand, or Western Europe)?	Y	N	Unsure
Has your child traveled (had contact with resident populations) for longer than 1 week to a country at high risk for tuberculosis?	Y	N	Unsure

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

American Academy of Pediatrics
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