Bright Futures Parent Supplemental Questionnaire 2 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

Are you getting enough rest?		Yes	No
Have you been out of the house without your baby?		Yes	No
Do you have someone who you can trust to look after your baby?		Yes	No
Do other family members and friends help you take care of your baby?		Yes	No
Do you and your partner spend time together?		Yes	No
Are you able to spend time alone with your older children?	N/A	Yes	No
Have you had a post-birth checkup?		Yes	No

Your Growing Baby: Infant Behavior

Do you enjoy caring for your baby?	Yes	No
Do you cuddle, talk, and play with your baby?	Yes	No
Does your baby have a regular schedule for naps and sleeping?	Yes	No
Can your baby sleep for 4–5 hours at night?	Yes	No
Does your baby sleep on his back?	Yes	No
Does your baby sleep in a crib?	Yes	No
Does your baby spend time with you on her tummy when awake?	Yes	No
Are you able to calm your baby?	Yes	No
Can you tell what your baby wants by how he cries?	Yes	No
How many hours per day does your baby watch TV?	_____ hours	

Your Baby and Family: Infant-Family Synchrony

Do you feel comfortable leaving your baby with someone else?	Yes	No
If you plan on returning to school or work, have you found child care?	Yes	No

Feeding Your Baby: Nutritional Adequacy

Can you tell when your baby is hungry?		Yes	No
Can you tell when your baby is full?		Yes	No
What are you feeding your baby?	Breast Milk	Formula	Both
Do you have any questions about pumping and storing breast milk?		No	Yes
Do you have a feeding routine?		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 keep one hand on your baby when changing her diaper?	Yes	No
Is your hot water temperature at or below 120°F at the faucet?	Yes	No
Do you keep plastic bags and latex balloons away from your baby to prevent choking?	Yes	No
Do you ever drink or carry hot liquids when holding your baby?	No	Yes

Bright Futures Medical Screening Questionnaire Newborn, 2 to 5 Day (First Week), and 2 Month Visits

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

Do you have concerns about how your child sees?	Y	N	Unsure