Bright Futures Parent Supplemental Questionnaire 6 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 Your Family Is Doing: Family Functioning

Are you and your partner getting along?	Yes	No
Is there someone who can help you with your baby?	Yes	No
How many hours per day does your baby spend in child care?	_____ hours	

Your Baby's Development: Infant Development

Does your baby watch you as you walk around the room?	Yes	No
Is your baby making eye contact with you?	Yes	No
Do you read to your baby every day?	Yes	No
Does your baby seem to get anxious or easily upset?	No	Yes
Can your baby calm herself?	Yes	No
Are you able to calm your baby?	Yes	No
Do you find activities for your baby when he is bored?	Yes	No
Do you play games with your baby, like peekaboo, or play music for him?	Yes	No
Does your baby "talk" (say things like "da," "ee," or "o")?	Yes	No
Does your baby have a regular daily schedule for feeding, napping, and playing?	Yes	No
Does your baby spend time with you on his tummy when awake?	Yes	No
Does your baby sleep for 6–8 hours at night?	Yes	No
Is your baby learning to go to sleep by herself?	Yes	No
Do you have a bedtime routine for your baby?	Yes	No
Does your baby sleep on his back?	Yes	No
Does your baby sleep in a crib?	Yes	No
How many hours per day does your baby watch TV?	_____ hours	

Feeding Your Baby: Nutrition and Feeding

What are you feeding your baby?	Breast Milk	Both	Formula

Is your baby eating solid foods?	Yes	No
Do you let your baby decide how much to eat?	Yes	No

Healthy Teeth: Oral Health

Are you using a soft toothbrush or cloth to clean your baby's teeth?	Yes	No
Do you give your baby a bottle in her crib?	No	Yes

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 in all vehicles?	Yes	No
Are you having any problems with your car safety seat?	No	Yes
Do you always stay close enough to touch your baby when he is in the bath, even if you use a bath ring?	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 have barriers around space heaters, woodstoves, or kerosene heaters?	Yes	No
Do you keep household cleaners, chemicals, and medicines locked up?	Yes	No
Does your baby ever use an infant walker?	No	Yes
Does anyone smoke around your child?	No	Yes
If you smoke, would you like information on how to stop?	Yes	No

Bright Futures Medical Screening Questionnaire
6 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 hears?	Y	N	Unsure
Do you have concerns about how your child sees?	Y	N	Unsure
Does your child have a sibling or playmate who has or had lead poisoning?	Y	N	Unsure
Does your child live in or regularly visit a house or child care facility built before 1978 that is being or has recently been (within the last 6 months) renovated or remodeled?	Y	N	Unsure
Does your child live in or regularly visit a house or child care facility built before 1950?	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
Has a family member or contact had tuberculosis or a positive tuberculin skin test?	Y	N	Unsure
Is your child infected with HIV?	Y	N	Unsure
Are cavities a problem for you or anyone else in your family?	Y	N	Unsure
Does your child sleep with a bottle?	Y	N	Unsure
Does your child continuously breastfeed through the night?	Y	N	Unsure

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

American Academy of Pediatrics

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