



Bright Futures Previsit 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 answer all of 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?

We are interested in answering your questions. Please check off the boxes for the topics you would like to discuss the most today.

How Your Family Is Doing	<input type="checkbox"/> Being a good parent and partner	<input type="checkbox"/> Where to go when you need help	<input type="checkbox"/> Finding good child care
	<input type="checkbox"/> Finding and joining playgroups		
Your Baby's Development	<input type="checkbox"/> How your baby learns	<input type="checkbox"/> How your baby can calm down alone	<input type="checkbox"/> How to keep your baby safe while sleeping
	<input type="checkbox"/> Bedtime routines	<input type="checkbox"/> Your baby falling asleep on his own	<input type="checkbox"/> Your child's weight
Feeding Your Baby	<input type="checkbox"/> Starting solid food	<input type="checkbox"/> How to add new foods	<input type="checkbox"/> How much food your baby should eat
	<input type="checkbox"/> Staying on breast milk or formula	<input type="checkbox"/> Food allergies	<input type="checkbox"/> Drinking from a cup
Healthy Teeth	<input type="checkbox"/> Brushing your baby's teeth		
	<input type="checkbox"/> Need for fluoride supplements		
Safety	<input type="checkbox"/> Keeping your home safe with a crawling baby	<input type="checkbox"/> Car safety seats	<input type="checkbox"/> Preventing burns, falls, choking, and poisoning
	<input type="checkbox"/> Bathing and water safety		

Questions About Your Baby

Have any of your baby's relatives developed new medical problems since your last visit? If yes, please describe: Yes No Unsure

Hearing	Do you have concerns about how your child hears?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Vision	Do you have concerns about how your child sees?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Lead	Does your child have a sibling or playmate who has or had lead poisoning?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> 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 past 6 months) renovated or remodeled?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Does your child live in or regularly visit a house or child care facility built before 1950?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Tuberculosis	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)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Has your child traveled (had contact with resident populations) for longer than 1 week to a country at high risk for tuberculosis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Has a family member or contact had tuberculosis or a positive tuberculin skin test?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Is your child infected with HIV?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Oral Health	Are cavities a problem for you or anyone else in your family?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Does your child sleep with a bottle?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Does your child continuously breastfeed through the night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure

Does your child have any special health care needs? No Yes, describe:

Have there been any major changes in your family lately? Move Job change Separation Divorce Death in the family Any other changes?



Over the past 2 weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things Not at all Several days More than half the days Nearly every day
2. Feeling down, depressed, or hopeless Not at all Several days More than half the days Nearly every day

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Does your child live with anyone who uses tobacco or spend time in any place where people smoke? No Yes

Your Growing and Developing Baby

Do you have specific concerns about your baby's learning, development, or behavior? No Yes, describe:

Check off each of the tasks that your baby is able to do.

- | | |
|---|--|
| <input type="checkbox"/> Rolls over | <input type="checkbox"/> Likes to look around |
| <input type="checkbox"/> Sits briefly, leans forward | <input type="checkbox"/> Begins name recognition |
| <input type="checkbox"/> Likes to play with you | <input type="checkbox"/> Smiles at people he knows |
| <input type="checkbox"/> Babbles and tries to "talk" to you | <input type="checkbox"/> Puts things in her mouth |



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