



Bright Futures Previsit 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 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 You Are Feeling	<input type="checkbox"/> Feeling sad <input type="checkbox"/> Using drugs <input type="checkbox"/> Using alcohol <input type="checkbox"/> Smoking <input type="checkbox"/> Getting back to work or school <input type="checkbox"/> Breastfeeding plans <input type="checkbox"/> Choosing child care
Your Baby and Family	<input type="checkbox"/> Asking for help when you need it <input type="checkbox"/> Community services that may be able to help your family <input type="checkbox"/> Violence at home/abuse
Getting to Know Your Baby	<input type="checkbox"/> Sleep/wake schedules <input type="checkbox"/> Where your baby sleeps <input type="checkbox"/> How your baby sleeps <input type="checkbox"/> How to keep your baby safe while sleeping <input type="checkbox"/> Bored baby <input type="checkbox"/> Tummy time for playtime with you <input type="checkbox"/> How to calm your baby <input type="checkbox"/> Crying too much
Feeding Your Baby	<input type="checkbox"/> How often you should feed your baby <input type="checkbox"/> How to know your baby is getting enough <input type="checkbox"/> What to feed your baby <input type="checkbox"/> Formula feeding <input type="checkbox"/> Help with breastfeeding <input type="checkbox"/> How to hold your baby while feeding <input type="checkbox"/> Burping <input type="checkbox"/> Using a pacifier <input type="checkbox"/> Worry about your baby's weight
Safety	<input type="checkbox"/> Car safety seats <input type="checkbox"/> Preventing falls <input type="checkbox"/> Choking from bracelets, necklaces, and toys with loops or strings

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

Vision	Do you have concerns about how your child sees?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Tuberculosis	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
	Was your child born in a country at high risk for tuberculosis (countries other than the United States, Canada, Australia, New Zealand, and 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

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

Other than your baby's birth, have there been any major changes in your family lately?

Move Job change Separation Divorce Death in the family Any other changes? Describe:

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

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

Adapted with permission from "Efficient Identification of Adults with Depression and Dementia," September 15, 2004, *American Family Physician*. Copyright © 2004 American Academy of Family Physicians. All Rights Reserved.

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 development, learning, or behavior? No Yes, describe:

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

- | | | |
|--|---|---|
| <input type="checkbox"/> If upset, able to calm | <input type="checkbox"/> Recognizes parents' voices | <input type="checkbox"/> Lifts head when on tummy |
| <input type="checkbox"/> Follows parents with eyes | <input type="checkbox"/> Smiles | |



American Academy
of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN™

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate. Original document included as part of *Bright Futures Tool and Resource Kit*. Copyright © 2010 American Academy of Pediatrics. All Rights Reserved. The American Academy of Pediatrics does not review or endorse any modifications made to this document and in no event shall the AAP be liable for any such changes.