CLEAR FORM

PATIENT NAME: _____ DATE: _____

Please print.

American Academy of Pediatrics

BRIGHT FUTURES PREVISIT QUESTIONNAIRE
4 MONTH VISIT

To provide you and your baby with the best possible health care, we would like to know how things are going. Please answer all the questions. **Maternal Depression screening is also part of this visit.** 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? ○ **No** ○ **Yes,** describe:

TELL US ABOUT YOUR BABY AND FAMILY.

What excites or delights you most about your baby?

Does your baby have special health care needs? ○ **No** ○ **Yes,** describe:

Have there been major changes lately in your baby's or family's life? ○ **No** ○ **Yes,** describe:

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

Does your baby live with anyone who smokes or spend time in places where people smoke or use e-cigarettes? ○ **No** ○ **Yes** ○ **Unsure**

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.

- ☐ Laugh out loud.
- ☐ Look for you or another caregiver when he is upset.
- ☐ Turn toward voices.
- ☐ Make extended cooing sounds.
- ☐ Support herself on her elbows and wrists when she is on her tummy.
- ☐ Roll over from his tummy to his back.
- ☐ Keep her hands open, not in a fist.
- ☐ Play with his fingers.
- ☐ Grasp objects.

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RISK ASSESSMENT

Anemia	Is your baby drinking anything other than breast milk or iron-fortified formula?	O No	O Yes	O Unsure
Hearing	Do you have concerns about how your baby hears?	O No	O Yes	O Unsure
Vision	Do you have concerns about how your baby sees?	O No	O Yes	O Unsure

ANTICIPATORY GUIDANCE

How are things going for you, your baby, and your family?

YOUR FAMILY'S HEALTH AND WELL-BEING

Living Situation		
Are you or is anyone else in your household exposed to harmful substances, such as lead? This may occur in a work environment such as construction, farming, or factory work.	O No	O Yes
Family Relationships and Support		
Do you have someone to turn to when problems arise?	O Yes	O No
Have you and your partner been able to find time alone?	O Yes	O No
If you have other children, are you able to spend time with each of them alone? O NA	O Yes	O No
Have you returned to work or school or do you plan to do so?	O No	O Yes
If so, have you been able to find someone to care for your baby?	O Yes	O No
Do you get a daily report on your baby's activities from your caregiver? It may include feeding, elimination, sleep, and playtime.	O Yes	O No

CARING FOR YOUR BABY

Your Changing Baby		
Are you able to calm your baby when he is crying?	O Yes	O No
Are you ever afraid that you or other caregivers may hurt the baby?	O No	O Yes
Are you beginning to understand your baby's likes and dislikes?	O Yes	O No
Do you have a daily routine for feedings, naps, and bedtime?	O Yes	O No
Is a TV, computer, tablet, or smartphone on in the background when your baby is in the room?	O No	O Yes
Does your baby watch TV or play on a tablet or smartphone? If yes, how much time each day? _____ hours	O No	O Yes
Do you put your baby on her tummy for short periods of time when she is awake and with you?	O Yes	O No
Do you and your baby enjoy quiet activities, such as reading, singing, or taking walks outside?	O Yes	O No

HEALTHY TEETH

Taking Care of Your Teeth		
Do you regularly see a dentist and brush and floss your teeth?	O Yes	O No
Taking Care of Your Baby's Teeth		
Is your baby showing signs of teething, such as drooling?	O No	O Yes
Do you let your baby have a bottle in the crib?	O No	O Yes
Do you have any questions about how to clean your baby's gums or teeth?	O No	O Yes

FEEDING YOUR BABY

General Information		
Are you feeding your baby anything other than breast milk or formula?	O No	O Yes
Are you comfortable waiting until your baby is about 6 months old to begin introducing solid foods?	O Yes	O No
Can you tell when your baby is hungry?	O Yes	O No
Can you tell when your baby is full?	O Yes	O No

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4 MONTH VISIT

FEEDING YOUR BABY (*CONTINUED*)

If you are breastfeeding, answer these questions.		
Are you still giving your baby vitamin D drops?	O Yes	O No
Do you take any supplements, herbs, vitamins, or medications?	O No	O Yes
Do you have questions about pumping and storing your breast milk?	O No	O Yes
If you are formula feeding, or providing formula supplementation, answer these questions.		
Are you using iron-fortified formula?	O Yes	O No
Do you have questions about using formula, such as how much it costs or how to prepare it?	O No	O Yes

SAFETY

Car and Home Safety		
Is your baby fastened securely in a rear-facing car safety seat in the back seat every time she rides in a vehicle?	O Yes	O No
Do you have any questions about what to do when you baby outgrows his current car safety seat?	O No	O Yes
Is your water heater set so the temperature at the faucet is at or below 120°F/49°C?	O Yes	O No
Do you ever drink or carry hot liquids (such as tea or coffee) when holding your baby?	O No	O Yes
Do you always keep one hand on your baby when changing diapers or clothing on a changing table, couch, or bed?	O Yes	O No
Safe Sleep		
Do you have any difficulty getting your baby to sleep on his back?	O No	O Yes
Have you moved your crib mattress to the lowest position to prevent falls?	O Yes	O No
Does your baby sleep in your room?	O Yes	O No

Consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents,* 4th Edition

For more information, go to https://brightfutures.aap.org.

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DEDICATED TO THE HEALTH OF ALL CHILDREN®