

PATIENT NAME: _____ DATE: _____

Please print.

American Academy of Pediatrics



BRIGHT FUTURES PREVISIT QUESTIONNAIRE

2 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.

- | | | |
|--|--|---|
| ☐ Smile back at you. | ☐ Make short cooing sounds. | ☐ Hold her chin up when she is on her stomach. |
| ☐ Make sounds that let you know he is happy or upset. | ☐ Move both arms and legs together. | ☐ Open and shut his hands. |

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RISK ASSESSMENT

Vision	Do you have concerns about how your baby sees?	☐ No	☐ Yes	☐ Unsure
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ANTICIPATORY GUIDANCE

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

YOUR FAMILY'S HEALTH AND WELL-BEING

Living Situation and Food Security			
Is permanent housing a worry for you?		☐ No	☐ Yes
Do you have the things you need to take care of your baby, such as a crib, a car safety seat, and diapers?		☐ Yes	☐ No
Does your home have enough heat, hot water, and electricity?		☐ Yes	☐ No
Do you have health insurance for yourself?		☐ Yes	☐ No
Within the past 12 months, were you ever worried whether your food would run out before you got money to buy more?		☐ No	☐ Yes
Within the past 12 months, did the food you bought not last, and you did not have money to get more?		☐ No	☐ Yes
Family Support			
Are you getting enough rest?		☐ Yes	☐ No
Have you been out of the house without your baby (such as to the store, to restaurants, or on a walk)?		☐ Yes	☐ No
Have you found someone to care for your baby when you return to work or school?		☐ Yes	☐ No
If yes, are you comfortable with these arrangements?		☐ NA	☐ Yes ☐ No

HOW YOU ARE FEELING

Have you had your 6-week after-birth checkup?		☐ Yes	☐ No
If you have other children, are you able to spend time with them?		☐ NA	☐ Yes ☐ No

CARING FOR YOUR BABY

Your Growing Baby		
Do you enjoy taking care of your baby?		☐ Yes ☐ No
Do you and your baby "talk" together during your daily routines?		☐ Yes ☐ No
Are you comfortable and confident in your abilities as a parent?		☐ Yes ☐ No
Is your baby beginning to develop regular sleep patterns?		☐ Yes ☐ No
Is a TV, computer, tablet, or smartphone on in the background when your baby is in the room?		☐ No ☐ Yes
Do you put your baby on her tummy for short periods of time when she is awake and with you?		☐ Yes ☐ No
Do you have ways to calm your baby when he is crying?		☐ Yes ☐ No
Are you ever afraid that you or other caregivers may hurt the baby?		☐ No ☐ Yes

FEEDING YOUR BABY

General Information		
Do you have any questions about feeding your baby?		☐ No ☐ Yes
Are you feeding your baby anything other than breast milk or formula?		☐ No ☐ Yes
Can you tell when your baby is hungry?		☐ Yes ☐ No
Can you tell when your baby is full?		☐ Yes ☐ No

2 MONTH VISIT

FEEDING YOUR BABY (CONTINUED)

If you are breastfeeding, answer these questions.		
Are you giving your baby vitamin D drops?	☐ Yes	☐ No
Do you have questions about pumping and storing your breast milk?	☐ No	☐ Yes
If you are formula feeding, or providing formula supplementation, answer these questions.		
Are you using iron-fortified formula?	☐ Yes	☐ No
Do you have questions about using formula, such as how much it costs or how to prepare it?	☐ No	☐ 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?	☐ Yes	☐ No
Are you having any problems using your car safety seat?	☐ No	☐ Yes
Is your water heater set so the temperature at the faucet is at or below 120°F/49°C?	☐ Yes	☐ No
Do you always stay within arm's reach whenever your baby is in or near water?	☐ Yes	☐ No
Do you have any questions about things you can do to keep your baby safe at home?	☐ No	☐ Yes
Safe Sleep		
Does your baby sleep on his back?	☐ Yes	☐ No
Does your baby sleep in a crib?	☐ Yes	☐ No
Does your baby sleep in your room?	☐ Yes	☐ 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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The information contained in this questionnaire should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances. Original questionnaire included as part of the *Bright Futures Tool and Resource Kit*, 2nd Edition.

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