



BRIGHT FUTURES PREVISIT QUESTIONNAIRE

6 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 and Oral Health Risk Assessment are 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:

Blank space for describing concerns or questions.

TELL US ABOUT YOUR BABY AND FAMILY.

What excites or delights you most about your baby?

Blank space for describing what excites or delights about the baby.

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

Blank space for describing special health care needs.

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

Blank space for describing major changes in life.

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

Blank space for describing medical problems in relatives.

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:

Blank space for describing concerns about development, learning, or behavior.

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

- Pat or smile at his reflection.
- Roll over from his back to his tummy.
- Pass a toy from one hand to another.
- Look when you call her name.
- Sit briefly without support.
- Rake small objects with 4 fingers.
- Babble.
- Make sounds such as "ga," "ma," and "ba."
- Bang small objects on a surface.

6 MONTH VISIT

RISK ASSESSMENT

| | | | | |
|---------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|---------------------------|------------------------------|
| Hearing | Do you have concerns about how your baby hears? | <input type="radio"/> No | <input type="radio"/> Yes | <input type="radio"/> Unsure |
| Lead | Does your baby live in or visit a home or child care facility with an identified lead hazard or a home built before 1960 that is in poor repair or that was renovated in the past 6 months? | <input type="radio"/> No | <input type="radio"/> Yes | <input type="radio"/> Unsure |
| Oral health | Does your baby's primary water source contain fluoride? | <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> Unsure |
| Tuberculosis | Was your baby or any household member born in, or has he or she traveled to, a country where tuberculosis is common (this includes countries in Africa, Asia, Latin America, and Eastern Europe)? | <input type="radio"/> No | <input type="radio"/> Yes | <input type="radio"/> Unsure |
| | Has your baby had close contact with a person who has tuberculosis disease or who has had a positive tuberculosis test result? | <input type="radio"/> No | <input type="radio"/> Yes | <input type="radio"/> Unsure |
| | Is your baby infected with HIV? | <input type="radio"/> No | <input type="radio"/> Yes | <input type="radio"/> Unsure |
| Vision | Do you have concerns about how your baby sees? | <input type="radio"/> No | <input type="radio"/> Yes | <input type="radio"/> Unsure |
| | Do your baby's eyes appear unusual or seem to cross? | <input type="radio"/> No | <input type="radio"/> Yes | <input type="radio"/> Unsure |
| | Do your baby's eyelids droop or does one eyelid tend to close? | <input type="radio"/> No | <input type="radio"/> Yes | <input type="radio"/> Unsure |
| | Have your baby's eyes ever been injured? | <input type="radio"/> No | <input type="radio"/> Yes | <input type="radio"/> Unsure |

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? | <input type="radio"/> No | <input type="radio"/> Yes |
| Do you have the things you need to take care of the baby, such as a crib, a car safety seat, and diapers? | <input type="radio"/> Yes | <input type="radio"/> No |
| Does your home have enough heat, hot water, electricity, and working appliances? | <input type="radio"/> Yes | <input type="radio"/> No |
| Within the past 12 months, were you ever worried whether your food would run out before you got money to buy more? | <input type="radio"/> No | <input type="radio"/> Yes |
| Within the past 12 months, did the food you bought not last, and you did not have money to get more? | <input type="radio"/> No | <input type="radio"/> Yes |
| Alcohol and Drugs | | |
| Does anyone in your household drink beer, wine, or liquor? | <input type="radio"/> No | <input type="radio"/> Yes |
| Do you or other family members use marijuana, cocaine, pain pills, narcotics, or other controlled substances? | <input type="radio"/> No | <input type="radio"/> Yes |
| Family Relationships and Support | | |
| Do you have people you can go to when you need help with your family? | <input type="radio"/> Yes | <input type="radio"/> No |
| Do you have child care or a reliable person to care for your baby? | <input type="radio"/> Yes | <input type="radio"/> No |

CARING FOR YOUR BABY

| | | |
|-----------------------------------------------------------------------------------------------------------|---------------------------|---------------------------|
| Your Baby's Development | | |
| Is your baby learning new things? | <input type="radio"/> Yes | <input type="radio"/> No |
| Is your baby adapting to new situations, people, and places? | <input type="radio"/> Yes | <input type="radio"/> No |
| Does your baby have ways to tell you what he wants and needs? | <input type="radio"/> Yes | <input type="radio"/> No |
| Does your baby respond when you look at books together? | <input type="radio"/> Yes | <input type="radio"/> No |
| Is a TV, computer, tablet, or smartphone on in the background while your baby is in the room? | <input type="radio"/> No | <input type="radio"/> Yes |
| Does your baby watch TV or play on a tablet or smartphone? If yes, how much time each day? _____ hours | <input type="radio"/> No | <input type="radio"/> Yes |
| Does your baby have a regular daily schedule for feeding, napping, playing, and sleeping? | <input type="radio"/> Yes | <input type="radio"/> No |
| Is your baby learning to go to sleep by himself? | <input type="radio"/> Yes | <input type="radio"/> No |
| Can your baby calm herself? | <input type="radio"/> Yes | <input type="radio"/> No |
| Do you have ways to help your baby calm himself if he cannot do it himself? | <input type="radio"/> Yes | <input type="radio"/> No |

Please print.

6 MONTH VISIT

HEALTHY TEETH

| | | |
|---------------------------------------------|--------------------------|---------------------------|
| Do you give your baby a bottle in her crib? | <input type="radio"/> No | <input type="radio"/> Yes |
|---------------------------------------------|--------------------------|---------------------------|

FEEDING YOUR BABY

| General Information | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|----------------------------------------------------|
| What are you feeding your baby? Check all that apply: _____ Breast milk _____ Formula _____ Both | | |
| Are you feeding your baby any drinks or foods besides breast milk or formula? Check all that apply: _____ Water _____ Juice _____ Cereal _____ Meats _____ Fruits _____ Vegetables _____ Other foods | | |
| Does your baby let you know when he likes or dislikes new foods that you have introduced? | <input type="radio"/> Yes | <input type="radio"/> No |
| Do you wash vegetables and fruits before serving them to your baby and family? | <input type="radio"/> Yes | <input type="radio"/> No |
| If you are breastfeeding, answer these questions. | | |
| Are you planning on continuing? | <input type="radio"/> NA | <input type="radio"/> Yes <input type="radio"/> No |
| Do you have questions about pumping and storing your breast milk? | <input type="radio"/> No | <input type="radio"/> Yes |
| Are you still giving your baby vitamin D drops and iron drops? | <input type="radio"/> Yes | <input type="radio"/> No |
| If you are formula feeding, or providing formula supplementation, answer these questions. | | |
| Are you using iron-fortified formula? | <input type="radio"/> Yes | <input type="radio"/> No |
| Do you have any questions or concerns about the formula, such as how much it costs or how to prepare it? | <input type="radio"/> No | <input type="radio"/> Yes |

SAFETY

| General Information | | |
|---------------------------------------------------------------------------------------------------------------------|---------------------------|---------------------------|
| Is your baby fastened securely in a rear-facing car safety seat in the back seat every time she rides in a vehicle? | <input type="radio"/> Yes | <input type="radio"/> No |
| Are you having any problems with your car safety seat? | <input type="radio"/> No | <input type="radio"/> Yes |
| Is your water heater set so the temperature at the faucet is at or below 120°F/49°C? | <input type="radio"/> Yes | <input type="radio"/> No |
| Do you have barriers around space heaters, woodstoves, and kerosene heaters? | <input type="radio"/> Yes | <input type="radio"/> No |
| Do you put a hat on your baby and apply sunscreen on her when you go outside? | <input type="radio"/> Yes | <input type="radio"/> No |
| Do you keep household cleaners, chemicals, and medicines locked up and out of your baby's sight and reach? | <input type="radio"/> Yes | <input type="radio"/> No |
| Do you always stay within arm's reach of your baby when he is in the bath? | <input type="radio"/> Yes | <input type="radio"/> No |
| Do you always keep one hand on your baby when changing diapers or clothing on a changing table, couch, or bed? | <input type="radio"/> Yes | <input type="radio"/> No |
| Do you have a gate at the top and bottom of all stairs in your home? | <input type="radio"/> Yes | <input type="radio"/> No |
| Safe Sleep | | |
| Do you continue to place your baby onto her back for sleep? | <input type="radio"/> Yes | <input type="radio"/> No |
| Does your baby sleep in a crib? | <input type="radio"/> Yes | <input type="radio"/> 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>.

American Academy of Pediatrics

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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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