PATIENT NAME:		DATE:	
	Please print.		

American Academy of Pediatrics

BRIGHT FUTURES PREVISIT QUESTIONNAIRE FIRST WEEK VISIT (3 TO 5 DAYS)



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. Thank you.

WHAT V	VOULD YOU LIKE TO TALK ABOUT	TODAY?
	L US ABOUT YOUR BABY AND FA	
what excites of delights you most about your	Saby:	
Does your baby have special health care need	ds? O No O Yes, describe:	
Have there been major changes lately in your	family's life? O No O Yes , describe:	
Have any of your baby's relatives developed ne please describe:	ew medical problems since your last visit? O No	○ Yes ○ Unsure If yes or unsure,
Does your baby live with anyone who smokes	or spend time in places where people smoke o	r use e-cigarettes? O No O Yes O Unsure
YOU	JR GROWING AND DEVELOPING E	BABY
Do you have specific concerns about your bal	oy's development, learning, or behavior? O No	○ Yes , describe:
Check off each of the tasks that your baby	is able to do.	
 ☐ Stay awake for a short time to feed. ☐ Make brief eye contact with an adult when held. ☐ Cry when she is uncomfortable. 	□ Calm to an adult's voice.□ Lift and turn his head to the side briefly when he is on his tummy.	☐ Move her arms and legs at the same time when startled.☐ Keep his hands in a fist.

PATIENT NAME:		DATE:
	Please print.	

FIRST WEEK VISIT (3 TO 5 DAYS)

	RISK ASSESSMENT			
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

O No	O Yes
O Yes	O No
O Yes	O No
O Yes	O No
O No	O Yes
O No	O Yes
O No	O Yes
O No	O Yes
	O Yes O Yes O Yes O No O No O No

GETTING TO KNOW YOUR BABY

How You Are Feeling			
Do you sleep when the baby sleeps?		O Yes	O No
Does your partner or do other family members help with the baby?		O Yes	O No
If you have other children, are you able to spend time with them?	O NA	O Yes	O No

CARING FOR YOUR BABY

Do you read to your baby?	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	
Is your baby able to fully awaken for feedings?	O Yes	O No	
Do you have questions about how to calm your baby?	O No	O Yes	
When to Call Your Doctor/Emergency Planning			
Do you know how to take your baby's temperature rectally? O Yes O N			
Do you have a list of emergency phone numbers?	O Yes	O No	
Do you have any questions about taking your baby out in public places?		O Yes	

FEEDING YOUR BABY

General Information			
Does your baby feed well?	O Yes	O No	
Do you have any questions about how your baby is growing?	O No	O Yes	
Are you having problems burping your baby?	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	
Does your baby have 5 or 6 wet disposable diapers (or 6–8 cloth diapers) and 3 or 4 stools a day?	O Yes	O No	

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	Please print	

FIRST WEEK VISIT (3 TO 5 DAYS)

FEEDING YOUR BABY (CONTINUED)

If you are breastfeeding, answer these questions.				
Is breastfeeding uncomfortable or painful?	O No	O Yes		
Do you eat foods that are high in protein (such as eggs, lean meat, poultry, fish, or beans) every day?	O Yes	O No		
Are you continuing to take prenatal vitamins?	O Yes	O No		
Do you take medications (either over-the-counter or prescription) or herbal supplements?	O No	O Yes		
Are you giving your baby vitamin D drops?	O Yes	O No		
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 any 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	
Are you having any problems with your car safety seat?	O No	O Yes	
Have you started developing habits that will help prevent you from ever forgetting your baby in the car?	O Yes	O No	
Is your water heater set so the temperature at the faucet is at or below 120°F/49°C?	O Yes	O No	
Safe Sleep			
Does your baby sleep on his back?	O Yes	O No	
Does your baby sleep in a crib?	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.



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.

The American Academy of Pediatrics (AAP) does not review or endorse any modifications made to this questionnaire and in no event shall the AAP be liable for any such changes.

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