CLEAR FORM

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

PATIENT NAME: _____ DATE: _____

Please print.

2 MONTH VISIT

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

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

HOW YOU ARE FEELING

Have you had your 6-week after-birth checkup?	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

Your Growing Baby		
Do you enjoy taking care of your baby?	O Yes	O No
Do you and your baby "talk" together during your daily routines?	O Yes	O No
Are you comfortable and confident in your abilities as a parent?	O Yes	O No
Is your baby beginning to develop regular sleep patterns?	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
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 have ways 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

FEEDING YOUR BABY

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

PATIENT NAME: _____ DATE: _____

Please print.

2 MONTH VISIT

FEEDING YOUR BABY (*CONTINUED*)

If you are breastfeeding, answer these questions.		
Are you giving your baby vitamin D drops?	O Yes	O No
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
Are you having any problems using your 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 always stay within arm's reach whenever your baby is in or near water?	O Yes	O No
Do you have any questions about things you can do to keep your baby safe at home?	O No	O Yes
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.

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®

Mankato Clinic

Health History
2 Months

Current Health History

A. Feeding/Nutrition:
   1. How is your child fed – Breast __ or Bottle __ or Both__
   1. How much? _____
   2. How often? _____

B. Elimination:
   1. How often does your child have a stool (messy pants)? _____
   2. Do you have any concerns with voiding (wet pants)? Yes or No

C. Hearing:
   1. Do you have any concerns about your child's hearing? Yes or No
   2. Does your baby respond to your voice? Yes or No