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 WO	OULD YOU LIKE TO TALK ABOUT	TODAY?
Do you have any concerns, questions, or proble		
TELL	US ABOUT YOUR BABY AND FAM	MILY.
What excites or delights you most about your ba	aby?	
Does your baby have special health care needs'	? O <b>No</b> O <b>Yes</b> , describe:	
Have there been major changes lately in your fa	mily's life? O <b>No</b> O <b>Yes,</b> describe:	
Have any of your baby's relatives developed new please describe:	medical problems since your last visit? O No	○ Yes ○ Unsure If yes or unsure,
Does your baby live with anyone who smokes of	r spend time in places where people smoke or	use e-cigarettes? O No O Yes O Unsure
YOUR	R GROWING AND DEVELOPING B	ABY
Do you have specific concerns about your baby'	's development, learning, or behavior? O <b>No</b>	O <b>Yes,</b> describe:
Check off each of the tasks that your baby is	able to do.	
	☐ Calm to an adult's voice. ☐ Lift and turn his head to the side briefly when he is on his tummy.	<ul><li>☐ Move her arms and legs at the same time when startled.</li><li>☐ Keep his hands in a fist.</li></ul>

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

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
Do you need help in finding community support services, such as WIC or food stamps?	O No	O Yes
Family Support		
Do you search the Internet to learn about how to care for your baby?	O No	O Yes

#### **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 No
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 No	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

<b>PATIENT NAME:</b>		<b>DATE:</b>
	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

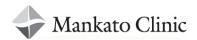
For more information, go to https://brightfutures.aap.org.



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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## Health History First Week Visit

## **Current Health History**

A.	Feeding/Nutrition:  1. How is your child fed – Breast or Bottle or Both  2. How much?
_	3. How often?
В.	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.	Tuberculosis (TB):
	1. Has your child ever been treated for tuberculosis? Yes or No
	2. Has your child ever been around anyone with
	Tuberculosis? Yes or No