CLEAR FORM

PATIENT NAME: _____ DATE: _____

Please print.

American Academy of Pediatrics

BRIGHT FUTURES PREVISIT QUESTIONNAIRE

9 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. **Child Development 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:

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.

- ☐ Use basic gestures, such as holding her arms out to be picked up or waving "bye-bye."
- ☐ Look for dropped objects.
- ☐ Play games such as peekaboo and pat-a-cake.
- ☐ Turn consistently when his name is called.
- ☐ Say, "Dada" or "Mama."
- ☐ Look around when you say things such as "Where's your bottle?" and "Where's your blanket?"
- ☐ Copy sounds that you make.
- ☐ Sit well without support.
- ☐ Pull herself to a standing position.
- ☐ Move easily between sitting and lying.
- ☐ Crawl on hands and knees.
- ☐ Pick up food and eat it.
- ☐ Pick up small objects with 3 fingers and a thumb.
- ☐ Let go of objects on purpose.
- ☐ Bang objects together.

PATIENT NAME: _____ DATE: _____

Please print.

9 MONTH VISIT

RISK ASSESSMENT

Hearing	Do you have concerns about how your baby hears?	O No	O Yes	O 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?	O No	O Yes	O Unsure
Oral health	Does your baby's primary water source contain fluoride?	O Yes	O No	O Unsure
Vision	Do you have concerns about how your baby sees?	O No	O Yes	O Unsure
	Do your baby's eyes appear unusual or seem to cross?	O No	O Yes	O Unsure
	Do your baby's eyelids droop or does one eyelid tend to close?	O No	O Yes	O Unsure
	Have your baby's eyes ever been injured?	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

Do you always feel safe in your home?	O Yes	O No
Has your partner, or another significant person in your life, ever hit, kicked, or shoved you, or physically hurt you or the baby?	O No	O Yes
Have you developed routines or other ways to take care of yourself?	O Yes	O No

CARING FOR YOUR BABY

Do you have a regular bedtime routine for your baby?	O Yes	O No
Does she wake up during the night?	O No	O Yes
Is your baby learning new things?	O Yes	O No
Does your baby have ways to tell you what he wants and needs?	O Yes	O No
Is a TV, computer, tablet, or smartphone on in the background while your baby is in the room?	O No	O Yes
Does your baby watch TV or play on a tablet or smartphone? If yes, how much time each day? _____hours	O No	O Yes
Have you made a family media use plan to help you balance media use with other family activities?	O Yes	O No

DISCIPLINE

Do you and your partner agree on how to handle your baby's behavior?		O Yes	O No
Do you limit the use of "No" to only the most important issues?		O Yes	O No
If you have other children, do you let them help with the baby as much as they can?	O NA	O Yes	O No

FEEDING YOUR BABY

Does your baby feed herself?		O Yes	O No
Does your baby drink from a cup?		O Yes	O No
Do you let your baby decide what and how much to eat?		O Yes	O No
Do you give your baby foods with different textures (such as pureed, blended, mashed, chopped, or lumps)?		O Yes	O No
If you are breastfeeding, are you planning on continuing?	O NA	O Yes	O No

SAFETY

Car and Home Safety		
Is your baby fastened securely in a rear-facing car safety seat in the back seat every time he rides in a vehicle?	O Yes	O No
Do you have any habits or reminders that prevent you from ever leaving your baby in the car?	O Yes	O No
Do you keep your baby away from the stove, fireplaces, and space heaters?	O Yes	O No

PATIENT NAME: _____ DATE: _____

Please print.

9 MONTH VISIT

SAFETY (*CONTINUED*)

Car and Home Safety (*continued*)		
Do you keep cleaners and medicines locked up and out of your baby's sight and reach?	○ Yes	○ No
Do you always stay within arm's reach of your baby when she is in the bathtub?	○ Yes	○ No
Do you keep furniture away from windows and use operable window guards on second-floor and higher windows? (Operable means that, in case of an emergency, an adult can open the window.)	○ Yes	○ No
Do you have a gate at the top and bottom of all stairs in your home?	○ Yes	○ No
Gun Safety		
Does anyone in your home or the homes where your baby spends time have a gun?	○ No	○ Yes
If yes, is the gun unloaded and locked up?	○ Yes	○ No
If yes, is the ammunition stored and locked up separately from the gun?	○ 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.

Mankato Clinic

Health History
9 Months

Current Health History

A. Feeding/Nutrition:
   1. How is your child fed – Breast __ or Bottle __ or Both__
   2. How much? _____
   3. 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