PATIENT NAME: _____ **DATE:** _____

Please print.

American Academy of Pediatrics

BRIGHT FUTURES PREVISIT QUESTIONNAIRE
1 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.

- ☐ Look at you.
- ☐ Follow you with her eyes.
- ☐ Comfort himself by doing things such as bringing his hands to his mouth.
- ☐ Start to get fussy when she is bored.
- ☐ Calm when he is picked up or spoken to.
- ☐ Look briefly at objects.
- ☐ Make short sounds such as "ooh" and "ah."
- ☐ Become alert when she hears unexpected sounds.
- ☐ Become quiet or turn when he hears your voice.
- ☐ Show signs she is sensitive to her surroundings (such as crying or startling) or need extra support to handle daily activities.
- ☐ Use different cries for hunger and tiredness.
- ☐ Move both arms and legs together.
- ☐ Hold his chin up when he is on his stomach.
- ☐ Open her fingers a little when at rest.

PATIENT NAME: _____ **DATE:** _____

Please print.

1 MONTH VISIT

RISK ASSESSMENT

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)?	O No	O Yes	O Unsure
	Has your baby had close contact with a person who has tuberculosis disease or who has had a positive tuberculosis test result?	O No	O Yes	O Unsure
	Is your baby infected with HIV?	O No	O Yes	O Unsure
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
Have you had any problems with mold or dampness in your home?		O No	O Yes
If your home has a basement, has it been checked for radon?	O NA	O Yes	O No
Do you use pesticides inside or outside your home?		O No	O Yes
Intimate Partner Violence			
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
Maternal Alcohol and Substance Use			
Does anyone in your household drink beer, wine, or liquor?		O No	O Yes
Do you or other family members use marijuana, cocaine, pain pills, narcotics, or other controlled substances?		O No	O Yes
Family Support			
Do you feel comfortable returning to work or school after the baby's birth?		O Yes	O No
Have you made arrangements for child care?		O Yes	O No

MOTHER'S HEALTH AND FAMILY RELATIONSHIPS

Have you had a post-birth checkup?		O Yes	O No
Does your partner or do other family members help care for the baby and help around the house?		O Yes	O No
If you have older children, are they getting along with the baby?	O NA	O Yes	O No

CARING FOR YOUR BABY

Is your baby sleeping well?	O Yes	O No
Does your baby use a pacifier?	O Yes	O No
Can you tell what your baby wants by how she cries?	O Yes	O No
Are you able to calm your baby?	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
Do you put your baby on his tummy for short periods of time when he is awake and with you?	O Yes	O No

PATIENT NAME: _____ **DATE:** _____

Please print.

1 MONTH VISIT

CARING FOR YOUR BABY (*CONTINUED*)

Medical Home After-hours Support		
Do you know how to take your baby's temperature rectally?	O Yes	O No
Do you know when to call your baby's doctor?	O Yes	O No
General Information		
Does your baby feed well?	O Yes	O No
Do you give your baby any supplements, herbs, special teas, or vitamins?	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
Do you ever prop the bottle rather than holding it or put your baby to bed with a bottle?	O No	O Yes
Are you able to burp your baby?	O Yes	O No
If you are breastfeeding, answer these questions.		
Is breastfeeding uncomfortable or painful?	O No	O Yes
Do you eat foods 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
Do you always keep one hand on your baby when changing diapers or clothing on a changing table, couch, or bed?	O Yes	O No
Do you have emergency phone numbers near every telephone and in your cell phone for rapid dial?	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

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

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Well Child | 1 Month Visit

Accompanied By:	Preferred Language:	Date/Time:	**Name:**

Weight (%):	Length (%):	Weight-for-length (%):	HC (%):	ID Number:

Vitals (*if indicated*): Temp:	HR:	Resp Rate:	SpO_2:	Birth Date:	Age:	Sex: M F

HISTORY

Concerns and Questions: ☐ None

Interval History: ☐ None

Medical History: ☐ Infant has special health care needs.

Areas reviewed and updated as needed

☐ Past Medical History (See Initial History Questionnaire.)

☐ Surgical History (See Initial History Questionnaire.)

☐ Problem List (See Problem List.)

Medications: ☐ None

☐ Reviewed and updated (See Medication Record.)

Allergies: ☐ No known drug allergies

Screening Results:

Newborn blood screening: ☐ Normal

☐ Abnormal

_____

Newborn hearing screening: ☐ Passed BL ☐ Referred _____

Nutrition:

☐ Breast milk:

Minutes per feeding: _____ Hours between feedings: _____

Feedings per 24 hours: _____

Problems with breastfeeding:

_____

Vitamin D supplements: _____ ☐ None

☐ Formula: Type/brand: _____ Source of water: _____

Feedings per 24 hours: _____ Ounces per feeding: _____

Problems with bottle-feeding: _____

Elimination: ☐ Regular soft stools ☐ Normal urine stream

_____

Sleep: ☐ Normal pattern ☐ On back ☐ Safe sleep surface

Behavior: ☐ No concerns

Activity (tummy time):

DEVELOPMENT

☑ = Normal development ☐ See Previsit Questionnaire.

Caregiver concerns about development: ☐ None ☐ Yes: _____

☐ SOCIAL LANGUAGE AND SELF-HELP
- Calms when picked up or spoken to
- Looks briefly at objects

☐ VERBAL LANGUAGE
- Alerts to unexpected sound
- Makes brief short vowel sounds

☐ GROSS MOTOR
- Holds chin up in prone

☐ FINE MOTOR
- Holds fingers more open at rest

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Name: _____

SOCIAL AND FAMILY HISTORY

Areas reviewed and updated as needed (See Initial History Questionnaire.): ☐ Social History ☐ Family History

Changes since last visit: _____

Smoking household: ☐ No ☐ Yes: _____

Parent adjustment to new infant: _____

Observation of parent-infant interaction: _____

Reactions of sibling to new infant: _____

Work plans: _____ Child care: ☐ Parent(s) ☐ Family ☐ In-home ☐ Center ☐ Other: _____

REVIEW OF SYSTEMS

☐ A 10-point review of systems was performed and results were negative except for any positive results listed below.
Bold = Focus area for this Bright Futures Visit

Constitutional: _____ **Respiratory:** _____ **Skin:** _____

Eyes: _____ **Gastrointestinal:** _____ Neurological: _____

Head, Ears, Nose, and Throat: _____ **Genitourinary:** _____ Other: _____

Cardiovascular: _____ Musculoskeletal: _____ Other: _____

PHYSICAL EXAMINATION

☑ = System examined **Bold** = Focus area for this Bright Futures Visit
Normal examination findings in text. Cross out abnormalities. Describe other findings in the area provided.

☐ **General:** Alert, active infant. **Normal interval growth in height, weight, and head circumference. Normal weight-for-length for age.**

_____

☐ **Head:** Normocephalic and atraumatic. **No positional skull deformities. Anterior fontanelle open and flat.** _____

☐ **Eyes: Normal eyes and eyelids. Fixes and follows. Red reflex present bilaterally. No opacification.** Normal funduscopic examination findings.

_____

☐ Ears, nose, and throat: Tympanic membranes with visible light reflex bilaterally. No oral lesions or thrush.

☐ Neck: Supple, with full range of motion without torticollis. _____

☐ **Heart:** Regular rate and rhythm. **No murmur. Symmetrical femoral pulses.** _____

☐ Respiratory: Breath sounds clear bilaterally. Comfortable work of breathing. _____

☐ **Abdomen:** Soft, with **no palpable masses. Well-healed umbilicus.** _____

☐ **Genitourinary:**

- ☐ **Normal female external genitalia.** _____
- ☐ Normal male external genitalia, with **testes palpable in scrotum bilaterally.** _____

☐ **Musculoskeletal: Spine straight. Negative Ortolani and Barlow maneuvers.** _____

☐ **Neurological:** Moves all extremities symmetrically. **Normal posture and tone.** Normal infant reflexes. **Attends to visual and auditory stimulation.**

_____

☐ **Skin:** Warm and well perfused. **No lesions, birthmarks, or bruising.** _____

Other comments: _____

ASSESSMENT

☐ Well child ☐ Normal interval growth (See growth chart.) ☐ Age-appropriate development

Well Child | 1 Month Visit

Name: _____

ANTICIPATORY GUIDANCE

☑ Discussed and/or handout given

☐ **SOCIAL DETERMINANTS OF HEALTH**
- Living situation and food security
- Environmental tobacco exposure
- Dampness and mold, radon, and pesticides
- Intimate partner violence
- Maternal alcohol and substance use
- Family support

☐ **PARENT AND FAMILY HEALTH**
- Postpartum checkup
- Maternal depression
- Family relationships

☐ **NUTRITION AND FEEDING**
- Feeding plans and choices
- General guidance on feeding
- Breastfeeding or formula-feeding guidance

☐ **INFANT BEHAVIOR AND DEVELOPMENT**
- Sleeping and waking
- Fussiness and attachment
- Media
- Playtime
- Medical home after-hours support

☐ **SAFETY**
- Car safety seats
- Safe sleep
- Preventing falls
- Emergency care

PLAN

Immunizations: ☐ Vaccine Administration Record reviewed Administered today: _____ ☐ Up-to-date for age

Universal Screening:

☐ Maternal depression: Screening tool used: _____ Result: ☐ Neg ☐ Pos: _____

Newborn blood screening: Result: ☐ Normal ☐ Needs follow-up: _____

Newborn hearing screening: Result: ☐ Passed BL ☐ Referred right/left/BL ☐ Needs follow-up: _____

Selective Screening (based on risk assessment) (See Previsit Questionnaire.):

☐ BP ☐ Tuberculosis ☐ Vision

Comments/results:

Follow-up:

☐ Routine follow-up at 2 months ☐ Next visit: _____ ☐ Referral to: _____

PRINT NAME.	SIGNATURE
Provider 1	
Provider 2	

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BRIGHT FUTURES HANDOUT ▶ **PARENT**

1 MONTH VISIT

Here are some suggestions from Bright Futures experts that may be of value to your family.

HOW YOUR FAMILY IS DOING

- If you are worried about your living or food situation, talk with us. Community agencies and programs such as WIC and SNAP can also provide information and assistance.
- Ask us for help if you have been hurt by your partner or another important person in your life. Hotlines and community agencies can also provide confidential help.
- Tobacco-free spaces keep children healthy. Don't smoke or use e-cigarettes. Keep your home and car smoke-free.
- Don't use alcohol or drugs.
- Check your home for mold and radon. Avoid using pesticides.

FEEDING YOUR BABY

- Feed your baby only breast milk or iron-fortified formula until she is about 6 months old.
- Avoid feeding your baby solid foods, juice, and water until she is about 6 months old.
- Feed your baby when she is hungry. Look for her to
  - Put her hand to her mouth.
  - Suck or root.
  - Fuss.
- Stop feeding when you see your baby is full. You can tell when she
  - Turns away
  - Closes her mouth
  - Relaxes her arms and hands
- Know that your baby is getting enough to eat if she has more than 5 wet diapers and at least 3 soft stools each day and is gaining weight appropriately.
- Burp your baby during natural feeding breaks.
- Hold your baby so you can look at each other when you feed her.
- Always hold the bottle. Never prop it.

If Breastfeeding

- Feed your baby on demand generally every 1 to 3 hours during the day and every 3 hours at night.
- Give your baby vitamin D drops (400 IU a day).
- Continue to take your prenatal vitamin with iron.
- Eat a healthy diet.

If Formula Feeding

- Always prepare, heat, and store formula safely. If you need help, ask us.
- Feed your baby 24 to 27 oz of formula a day. If your baby is still hungry, you can feed her more.

HOW YOU ARE FEELING

- Take care of yourself so you have the energy to care for your baby. Remember to go for your post-birth checkup.
- If you feel sad or very tired for more than a few days, let us know or call someone you trust for help.
- Find time for yourself and your partner.

CARING FOR YOUR BABY

- Hold and cuddle your baby often.
- Enjoy playtime with your baby. Put him on his tummy for a few minutes at a time when he is awake.
- Never leave him alone on his tummy or use tummy time for sleep.
- When your baby is crying, comfort him by talking to, patting, stroking, and rocking him. Consider offering him a pacifier.
- *Never hit or shake your baby.*
- Take his temperature rectally, not by ear or skin. A fever is a rectal temperature of 100.4°F/38.0°C or higher. Call our office if you have any questions or concerns.
- Wash your hands often.

Helpful Resources: National Domestic Violence Hotline: 800-799-7233 | Smoking Quit Line: 800-784-8669
Information About Car Safety Seats: www.safercar.gov/parents | Toll-free Auto Safety Hotline: 888-327-4236

1 MONTH VISIT—PARENT

SAFETY

- Use a rear-facing–only car safety seat in the back seat of all vehicles.
- Never put your baby in the front seat of a vehicle that has a passenger airbag.
- Make sure your baby always stays in her car safety seat during travel. If she becomes fussy or needs to feed, stop the vehicle and take her out of her seat.
- Your baby's safety depends on you. Always wear your lap and shoulder seat belt. Never drive after drinking alcohol or using drugs. Never text or use a cell phone while driving.
- Always put your baby to sleep on her back in her own crib, not in your bed.
  - Your baby should sleep in your room until she is at least 6 months old.
  - Make sure your baby's crib or sleep surface meets the most recent safety guidelines.
  - Don't put soft objects and loose bedding such as blankets, pillows, bumper pads, and toys in the crib.
- Swaddling should be used only with babies younger than 2 months.
- If you choose to use a mesh playpen, get one made after February 28, 2013.
- Keep hanging cords or strings away from your baby. Don't let your baby wear necklaces or bracelets.
- Always keep a hand on your baby when changing diapers or clothing on a changing table, couch, or bed.
- Learn infant CPR. Know emergency numbers. Prepare for disasters or other unexpected events by having an emergency plan.

WHAT TO EXPECT AT YOUR BABY'S 2 MONTH VISIT

We will talk about

- Taking care of your baby, your family, and yourself
- Getting back to work or school and finding child care
- Getting to know your baby
- Feeding your baby
- Keeping your baby safe at home and in the car

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