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.

SAMPLE
For Review and Reference Only

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 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.

- ☐ 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

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

SAMPLE
For Review and Reference Only

PATIENT NAME: ______________________ **DATE:** __________

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

SAMPLE
For Review and Reference Only

Consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents,* 4th Edition

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

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Well Child | First Week Visit (3 to 5 Days)

Accompanied By:	Preferred Language:	Date/Time:	**Name:**
Weight (%):	Length (%):	HC (%):	ID Number:

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

HISTORY

Concerns and Questions: ☐ 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

Birth History: ☐ Full-term ☐ Preterm: ____weeks ☐ Post-term: ____weeks

☐ Vaginal ☐ Cesarean Apgar (1 min/5 min/10 min): _____/_____/_____

Birth weight: _______________ Discharge weight: _____________

Percent weight loss since birth: _____________

Newborn hearing screening: ☐ Passed BL ☐ Referred: ________ ☐ Not done

Newborn blood screening: Collected: _____/_____/_____ ☐ Not done

CCHD screening: ☐ Passed ☐ Referred: ________________ ☐ Not done

Blood type: Maternal: _____ Infant: _____

Coombs test/DAT: ☐ Pos ☐ Neg ☐ NA

Bilirubin screening: _________________ ☐ Not done

Birth History (*continued*):

Maternal lab tests: Hep B: ☐ Pos ☐ Neg ☐ Unk

HIV: ☐ Pos ☐ Neg ☐ Unk

GBS: ☐ Pos ☐ Neg ☐ Unk

Prophylaxis: ☐ Adequate ☐ Inadequate ☐ NA

Hep B vaccine: Given: _____/_____/_____ ☐ Not given

Vitamin K: ☐ Given ☐ Declined Erythromycin: ☐ Given ☐ Declined

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

SAMPLE
For Review and Reference Only

DEVELOPMENT

☑ = Normal development ☐ See Previsit Questionnaire.

Caregiver concerns about development: ☐ None ☐ Yes: ________________________________

☐ SOCIAL LANGUAGE AND SELF-HELP
- Makes brief eye contact

☐ VERBAL LANGUAGE
- Cries with discomfort
- Calms to adult voice

☐ GROSS MOTOR
- Reflexively moves arms and legs
- Turns head to side when on stomach

☐ FINE MOTOR
- Holds fingers closed
- Grasps reflexively

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Well Child | First Week Visit (3 to 5 Days)

Name: ____________________

SOCIAL AND FAMILY HISTORY

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

Smoking household: ☐ No ☐ Yes: ____________________

Parent adjustment to new infant: ____________________

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: ____________________

Eyes: ____________________

Head, Ears, Nose, and Throat: ____________________

Cardiovascular: ____________________

Respiratory: ____________________

Gastrointestinal: ____________________

Genitourinary: ____________________

Musculoskeletal: ____________________

Skin: ____________________

Neurological: ____________________

Other: ____________________

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. No congenital anomalies or dysmorphic features.** ____________________

☐ **Head: Normocephalic and atraumatic. Normal sutures. 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: Normal external ears, no pits or tags, nares patent, and palate intact.

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

☐ **Heart:** Regular rate and rhythm. **No murmur. Equal symmetrical femoral and upper extremity pulses.** ____________________

☐ Respiratory: Breath sounds clear bilaterally. Comfortable work of breathing without retractions. ____________________

☐ **Abdomen:** Soft, with **no palpable masses. Well-appearing dry umbilical stump.** ____________________

☐ **Genitourinary:**

- ☐ **Normal female external genitalia.** No significant labial swelling. ____________________
- ☐ Normal male external genitalia, with **testes palpable in scrotum bilaterally.** ____________________

☐ **Musculoskeletal: Spine straight without dimples, sinus tracts, or hair tufts. Clavicles intact. Negative Ortolani and Barlow maneuvers.**
____

☐ **Neurological: Moves all extremities equally. Normal posture and tone. Normal neonatal reflexes.** ____________________

☐ **Skin:** Warm and well perfused. **No rashes or jaundice.** No birthmarks or lesions. ____________________

Other comments: ____________________

ASSESSMENT

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

SAMPLE For Review and Reference Only

Well Child | First Week Visit (3 to 5 Days)

Name: ____________________

ANTICIPATORY GUIDANCE

☑ Discussed and/or handout given

☐ **SOCIAL DETERMINANTS OF HEALTH**
- Living situation and food security
- Environmental tobacco exposure
- Family support

☐ **PARENT AND FAMILY HEALTH**
- Transition home and sibling adjustment

☐ **NUTRITION AND FEEDING**
- General feeding guidance
- Breast/formula-feeding guidance

☐ **NEWBORN BEHAVIOR AND CARE**
- Early brain development; calming
- When to call; CPR; illness prevention

☐ **SAFETY**
- Car safety seats
- Safe sleep
- Heatstroke prevention
- Burn prevention

PLAN

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

Universal Screening:

Newborn blood screening: Result: ☐ Pending ☐ 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 ☐ Vision

Comments/results:

Follow-up:

☐ Routine follow-up at 1 month ☐ Next visit: __________ ☐ Referral to: ____________________

PRINT NAME.	SIGNATURE
Provider 1	
Provider 2	

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SAMPLE
For Review and Reference Only

BRIGHT FUTURES HANDOUT ▶ **PARENT**

FIRST WEEK VISIT (3 TO 5 DAYS)

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

SAMPLE
For Review and Reference Only

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.
- Tobacco-free spaces keep children healthy. Don't smoke or use e-cigarettes. Keep your home and car smoke-free.
- Take help from family and friends.

FEEDING YOUR BABY

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

If Breastfeeding

- Feed your baby on demand. Expect at least 8 to 12 feedings per day.
- A lactation consultant can give you information and support on how to breastfeed your baby and make you more comfortable.
- Begin giving your baby vitamin D drops (400 IU a day).
- Continue your prenatal vitamin with iron.
- Eat a healthy diet; avoid fish high in mercury.

If Formula Feeding

- Offer your baby 2 oz of formula every 2 to 3 hours. If he is still hungry, offer him more.

HOW YOU ARE FEELING

- Try to sleep or rest when your baby sleeps.
- Spend time with your other children.
- Keep up routines to help your family adjust to the new baby.

BABY CARE

- Sing, talk, and read to your baby; avoid TV and digital media.
- Help your baby wake for feeding by patting her, changing her diaper, and undressing her.
- Calm your baby by stroking her head or gently rocking her.
- *Never hit or shake your baby.*
- Take your baby's temperature with a rectal thermometer, not by ear or skin; a fever is a rectal temperature of 100.4°F/38.0°C or higher. Call us anytime if you have questions or concerns.
- Plan for emergencies: have a first aid kit, take first aid and infant CPR classes, and make a list of phone numbers.
- Wash your hands often.
- Avoid crowds and keep others from touching your baby without clean hands.
- Avoid sun exposure.

Helpful Resources: Smoking Quit Line: 800-784-8669 | Poison Help Line: 800-222-1222
Information About Car Safety Seats: www.safercar.gov/parents | Toll-free Auto Safety Hotline: 888-327-4236

FIRST WEEK VISIT (3 TO 5 DAYS)—PARENT

SAFETY

- Use a rear-facing–only car safety seat in the back seat of all vehicles.
- Make sure your baby always stays in his car safety seat during travel. If he becomes fussy or needs to feed, stop the vehicle and take him out of his 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.
- Never leave your baby in the car alone. Start habits that prevent you from ever forgetting your baby in the car, such as putting your cell phone in the back seat.
- Always put your baby to sleep on his back in his own crib, not your bed.
  - Your baby should sleep in your room until he is at least 6 months old.
  - Make sure your baby's crib or sleep surface meets the most recent safety guidelines.
- If you choose to use a mesh playpen, get one made after February 28, 2013.
- Swaddling should be used only with babies younger than 2 months.
- Prevent scalds or burns. Don't drink hot liquids while holding your baby.
- Prevent tap water burns. Set the water heater so the temperature at the faucet is at or below 120°F /49°C.

WHAT TO EXPECT AT YOUR BABY'S 1 MONTH VISIT

We will talk about

- Taking care of your baby, your family, and yourself
- Promoting your health and recovery
- Feeding your baby and watching her grow
- Caring for and protecting your baby
- Keeping your baby safe at home and in the car

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