

American Academy of Pediatrics



BRIGHT FUTURES PREVISIT QUESTIONNAIRE

4 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.

- | | | |
|--|---|--|
| <input type="checkbox"/> Laugh out loud. | <input type="checkbox"/> Turn toward voices. | <input type="checkbox"/> Roll over from his tummy to his back. |
| <input type="checkbox"/> Look for you or another caregiver when he is upset. | <input type="checkbox"/> Make extended cooing sounds. | <input type="checkbox"/> Keep her hands open, not in a fist. |
| | <input type="checkbox"/> Support herself on her elbows and wrists when she is on her tummy. | <input type="checkbox"/> Play with his fingers. |
| | | <input type="checkbox"/> Grasp objects. |

4 MONTH VISIT

RISK ASSESSMENT

Anemia	Is your baby drinking anything other than breast milk or iron-fortified formula?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
Hearing	Do you have concerns about how your baby hears?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
Vision	Do you have concerns about how your baby sees?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure

ANTICIPATORY GUIDANCE

How are things going for you, your baby, and your family?

YOUR FAMILY'S HEALTH AND WELL-BEING

Living Situation			
Are you or is anyone else in your household exposed to harmful substances, such as lead? This may occur in a work environment such as construction, farming, or factory work.			<input type="radio"/> No <input type="radio"/> Yes
Family Relationships and Support			
Do you have someone to turn to when problems arise?			<input type="radio"/> Yes <input type="radio"/> No
Have you and your partner been able to find time alone?			<input type="radio"/> Yes <input type="radio"/> No
If you have other children, are you able to spend time with each of them alone?			<input type="radio"/> NA <input type="radio"/> Yes <input type="radio"/> No
Have you returned to work or school or do you plan to do so?			<input type="radio"/> No <input type="radio"/> Yes
If so, have you been able to find someone to care for your baby?			<input type="radio"/> Yes <input type="radio"/> No
Do you get a daily report on your baby's activities from your caregiver? It may include feeding, elimination, sleep, and playtime.			<input type="radio"/> Yes <input type="radio"/> No

CARING FOR YOUR BABY

Your Changing Baby			
Are you able to calm your baby when he is crying?			<input type="radio"/> Yes <input type="radio"/> No
Are you ever afraid that you or other caregivers may hurt the baby?			<input type="radio"/> No <input type="radio"/> Yes
Are you beginning to understand your baby's likes and dislikes?			<input type="radio"/> Yes <input type="radio"/> No
Do you have a daily routine for feedings, naps, and bedtime?			<input type="radio"/> Yes <input type="radio"/> No
Is a TV, computer, tablet, or smartphone on in the background when your baby is in the room?			<input type="radio"/> No <input type="radio"/> Yes
Does your baby watch TV or play on a tablet or smartphone?			<input type="radio"/> No <input type="radio"/> Yes
If yes, how much time each day? _____ hours			
Do you put your baby on her tummy for short periods of time when she is awake and with you?			<input type="radio"/> Yes <input type="radio"/> No
Do you and your baby enjoy quiet activities, such as reading, singing, or taking walks outside?			<input type="radio"/> Yes <input type="radio"/> No

HEALTHY TEETH

Taking Care of Your Teeth			
Do you regularly see a dentist and brush and floss your teeth?			<input type="radio"/> Yes <input type="radio"/> No
Taking Care of Your Baby's Teeth			
Is your baby showing signs of teething, such as drooling?			<input type="radio"/> No <input type="radio"/> Yes
Do you let your baby have a bottle in the crib?			<input type="radio"/> No <input type="radio"/> Yes
Do you have any questions about how to clean your baby's gums or teeth?			<input type="radio"/> No <input type="radio"/> Yes

FEEDING YOUR BABY

General Information			
Are you feeding your baby anything other than breast milk or formula?			<input type="radio"/> No <input type="radio"/> Yes
Are you comfortable waiting until your baby is about 6 months old to begin introducing solid foods?			<input type="radio"/> Yes <input type="radio"/> No
Can you tell when your baby is hungry?			<input type="radio"/> Yes <input type="radio"/> No
Can you tell when your baby is full?			<input type="radio"/> Yes <input type="radio"/> No

4 MONTH VISIT

FEEDING YOUR BABY (CONTINUED)

If you are breastfeeding, answer these questions.		
Are you still giving your baby vitamin D drops?	<input type="radio"/> Yes	<input type="radio"/> No
Do you take any supplements, herbs, vitamins, or medications?	<input type="radio"/> No	<input type="radio"/> Yes
Do you have questions about pumping and storing your breast milk?	<input type="radio"/> No	<input type="radio"/> Yes
If you are formula feeding, or providing formula supplementation, answer these questions.		
Are you using iron-fortified formula?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have questions about using formula, such as how much it costs or how to prepare it?	<input type="radio"/> No	<input type="radio"/> 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?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have any questions about what to do when your baby outgrows his current car safety seat?	<input type="radio"/> No	<input type="radio"/> Yes
Is your water heater set so the temperature at the faucet is at or below 120°F/49°C?	<input type="radio"/> Yes	<input type="radio"/> No
Do you ever drink or carry hot liquids (such as tea or coffee) when holding your baby?	<input type="radio"/> No	<input type="radio"/> Yes
Do you always keep one hand on your baby when changing diapers or clothing on a changing table, couch, or bed?	<input type="radio"/> Yes	<input type="radio"/> No
Safe Sleep		
Do you have any difficulty getting your baby to sleep on his back?	<input type="radio"/> No	<input type="radio"/> Yes
Have you moved your crib mattress to the lowest position to prevent falls?	<input type="radio"/> Yes	<input type="radio"/> No
Does your baby sleep in your room?	<input type="radio"/> Yes	<input type="radio"/> 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>.



Well Child | 4 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.)

Current Medications: ☐ None

Allergies: ☐ No known drug allergies

Nutrition:

☐ Breast milk: 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: _____

Solids: ☐ Not yet started

Giving: _____

Elimination: ☐ Regular soft stools

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

Behavior: ☐ No concerns

Activity (tummy time): ☐ No concerns

DEVELOPMENT

☒ = Normal development ☐ See Previsit Questionnaire.

Caregiver concerns about development: ☐ None ☐ Yes: _____

☐ SOCIAL LANGUAGE AND SELF-HELP

- Laughs aloud

☐ VERBAL LANGUAGE

- Turns to voice
- Vocalizes with extended cooing

☐ GROSS MOTOR

- Rolls over prone to supine
- Supports on elbows and wrists in prone

☐ FINE MOTOR

- Keeps hands unfisted
- Plays with fingers in midline
- Grasps object

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®



The recommendations in this form do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate. Original form 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 form and in no event shall the AAP be liable for any such changes.

© 2019 American Academy of Pediatrics. All rights reserved.

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: _____

Parental support and work-family balance: _____

Observation of parent-infant interaction: _____

Parents working outside home: ☐ One parent ☐ Both parents 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:** **Fixes and follows. Red reflex present bilaterally. No opacification.** Normal fundoscopic 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. _____

☐ Genitourinary: _____

☐ Normal female external genitalia. _____

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

☐ **Musculoskeletal:** Spine straight. **No leg length discrepancy, thigh folds symmetrical, and normal hip abduction.** _____

☐ **Neurological:** **Moves all extremities symmetrically. Normal strength and tone. Decreasing infant reflexes.** _____

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

Other comments: _____

ASSESSMENT

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

ANTICIPATORY GUIDANCE

☒ Discussed and/or handout given☐ SOCIAL DETERMINANTS OF HEALTH

- Environmental risk: lead
- Family relationships and support
- Child care

☐ ORAL HEALTH

- Maternal oral health
- Teething and drooling
- Good oral hygiene

☐ NUTRITION AND FEEDING

- General guidance on feeding
- Feeding choices
- Delaying solid foods
- Breastfeeding or formula-feeding guidance
- Supplements and over-the-counter medications

☐ INFANT BEHAVIOR AND DEVELOPMENT

- Infant self-calming
- Parent-infant communication
- Consistent daily routines
- Media
- Playtime

☐ SAFETY

- Car safety seats
- Safe sleep
- Safe home environment

PLAN

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

Universal Screening:

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

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

☐ BP ☐ Anemia ☐ Hearing ☐ Vision

Comments/results: _____

Follow-up:

☐ Routine follow-up at 6 months ☐ Next visit: _____ ☐ Referral to: _____

PRINT NAME.

SIGNATURE

Provider 1

Provider 2

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

BRIGHT FUTURES HANDOUT ► PARENT

4 MONTH VISIT

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

✓ HOW YOUR FAMILY IS DOING

- Learn if your home or drinking water has lead and take steps to get rid of it. Lead is toxic for everyone.
- Take time for yourself and with your partner. Spend time with family and friends.
- Choose a mature, trained, and responsible babysitter or caregiver.
- You can talk with us about your child care choices.

✓ FEEDING YOUR BABY

- For babies at 4 months of age, breast milk or iron-fortified formula remains the best food. Solid foods are discouraged until about 6 months of age.
- Avoid feeding your baby too much by following the baby's signs of fullness, such as
 - Leaning back
 - Turning away

If Breastfeeding

- Providing only breast milk for your baby for about the first 6 months after birth provides ideal nutrition. It supports the best possible growth and development.
- Be proud of yourself if you are still breastfeeding. Continue as long as you and your baby want.
- Know that babies this age go through growth spurts. They may want to breastfeed more often and that is normal.
- If you pump, be sure to store your milk properly so it stays safe for your baby. We can give you more information.
- Give your baby vitamin D drops (400 IU a day).
- Tell us if you are taking any medications, supplements, or herbal preparations.

If Formula Feeding

- Make sure to prepare, heat, and store the formula safely.
- Feed on demand. Expect him to eat about 30 to 32 oz daily.
- Hold your baby so you can look at each other when you feed him.
- Always hold the bottle. Never prop it.
- Don't give your baby a bottle while he is in a crib.

✓ YOUR CHANGING BABY

- Create routines for feeding, nap time, and bedtime.
- Calm your baby with soothing and gentle touches when she is fussy.
- Make time for quiet play.
 - Hold your baby and talk with her.
 - Read to your baby often.
- Encourage active play.
 - Offer floor gyms and colorful toys to hold.
 - Put your baby on her tummy for playtime. Don't leave her alone during tummy time or allow her to sleep on her tummy.
- Don't have a TV on in the background or use a TV or other digital media to calm your baby.

✓ HEALTHY TEETH

- Go to your own dentist twice yearly. It is important to keep your teeth healthy so you don't pass bacteria that cause cavities on to your baby.
- Don't share spoons with your baby or use your mouth to clean the baby's pacifier.
- Use a cold teething ring if your baby's gums are sore from teething.
- Don't put your baby in a crib with a bottle.
- Clean your baby's gums and teeth (as soon as you see the first tooth) 2 times per day with a soft cloth or soft toothbrush and a small smear of fluoride toothpaste (no more than a grain of rice).

Helpful Resources:

Information About Car Safety Seats: www.safercar.gov/parents | Toll-free Auto Safety Hotline: 888-327-4236

4 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.
- 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 of age.
 - 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.
- Drop-side cribs should not be used.
- Lower the crib mattress.
- If you choose to use a mesh playpen, get one made after February 28, 2013.
- Prevent tap water burns. Set the water heater so the temperature at the faucet is at or below 120°F/49°C.
- Prevent scalds or burns. Don't drink hot drinks when holding your baby.
- Keep a hand on your baby on any surface from which she might fall and get hurt, such as a changing table, couch, or bed.
- Never leave your baby alone in bathwater, even in a bath seat or ring.
- Keep small objects, small toys, and latex balloons away from your baby.
- Don't use a baby walker.

WHAT TO EXPECT AT YOUR BABY'S 6 MONTH VISIT

We will talk about

- Caring for your baby, your family, and yourself
- Teaching and playing with your baby
- Brushing your baby's teeth
- Introducing solid food
- Keeping your baby safe at home, outside, and in the car

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®



The information contained in this handout 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 handout included as part of the *Bright Futures Tool and Resource Kit*, 2nd Edition.

Inclusion in this handout does not imply an endorsement by the American Academy of Pediatrics (AAP). The AAP is not responsible for the content of the resources mentioned in this handout. Web site addresses are as current as possible but may change at any time.

The American Academy of Pediatrics (AAP) does not review or endorse any modifications made to this handout and in no event shall the AAP be liable for any such changes.

© 2019 American Academy of Pediatrics. All rights reserved.