



Bright Futures Previsit Questionnaire 2 to 5 Day (First Week) Visit

For us to provide you and your baby with the best possible health care, we would like to know how things are going. Please answer all of the questions. 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?

We are interested in answering your questions. Please check off the boxes for the topics you would like to discuss the most today.

How You Are Feeling	<input type="checkbox"/> Your health <input type="checkbox"/> Feeling sad <input type="checkbox"/> Family stress <input type="checkbox"/> Unwanted advice <input type="checkbox"/> Starting a daily routine
Getting Used to Your Baby	<input type="checkbox"/> How you are doing with your baby <input type="checkbox"/> Calming your baby <input type="checkbox"/> Crib safety <input type="checkbox"/> Where your baby sleeps <input type="checkbox"/> How your baby sleeps <input type="checkbox"/> Placing baby on back to sleep
Feeding Your Baby	<input type="checkbox"/> Gaining weight <input type="checkbox"/> How your baby shows if he/she is hungry or full <input type="checkbox"/> Drinking enough <input type="checkbox"/> Jaundice (skin is yellow) <input type="checkbox"/> Burping <input type="checkbox"/> Breastfeeding <input type="checkbox"/> Formula
Safety	<input type="checkbox"/> Car safety seat <input type="checkbox"/> Cigarette smoke <input type="checkbox"/> Water heater temperature
Baby Care	<input type="checkbox"/> When to call the doctor's office <input type="checkbox"/> Taking your baby's temperature <input type="checkbox"/> Not getting sick <input type="checkbox"/> Hand washing <input type="checkbox"/> Emergency situations <input type="checkbox"/> Leaving the house <input type="checkbox"/> Skin care <input type="checkbox"/> Sunburns

Questions About Your Baby

Have any of your baby's relatives developed new medical problems since your last visit? If yes, please describe: Yes No Unsure

Vision Do you have concerns about how your child sees? Yes No Unsure

Does your child have any special health care needs? No Yes, describe:

Other than your baby's birth, have there been any major changes in your family lately?

Move Job change Separation Divorce Death in the family Any other changes? Describe:

Over the past 2 weeks, how often have you been bothered by any of the following problems?

- Little interest or pleasure in doing things Not at all Several days More than half the days Nearly every day
- Feeling down, depressed, or hopeless Not at all Several days More than half the days Nearly every day

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Does your child live with anyone who uses tobacco or spend time in any place where people smoke? No Yes

Your Growing and Developing Baby

Do you have specific concerns about how your baby is growing, learning, or acting? No Yes, describe:

Check off each of the tasks that your baby is able to do.

- | | |
|--|--|
| <input type="checkbox"/> Eats well | <input type="checkbox"/> Follows your face |
| <input type="checkbox"/> Turns and calms to your voice | <input type="checkbox"/> Can suck, swallow, and breathe easily |



American Academy of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN™

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