Patient:_____ Date:_____ MRN:_____

Bright Futures Previsit Questionnaire
2 Month 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	☐ Getting back to normal activities ☐ Feeling sad ☐ Your partner helping you take care of your home and baby ☐ Help taking care of your baby ☐ Brothers and sisters getting along with your baby ☐ Taking time for yourself ☐ Finding time alone with your partner
Your Growing Baby	☐ How you are doing with your baby ☐ Where your baby sleeps ☐ How your baby sleeps ☐ How to keep your baby safe while sleeping ☐ Tummy time for playtime with you ☐ Rolling over ☐ Talking with your baby ☐ Calming your baby ☐ Daily routines
Your Baby and Family	☐ Leaving your baby when going to work or school ☐ Finding good child care
Feeding Your Baby	☐ Feeding routine ☐ When to begin solid food ☐ Holding ☐ Burping ☐ Your child's weight ☐ Knowing when your baby is hungry or full ☐ Help with breastfeeding ☐ Formula feeding
Safety	☐ Car safety seats ☐ How to check hot water temperature ☐ Choking ☐ Preventing falls from rolling over ☐ Bathtub safety ☐ Cigarette smoke

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?

_____

Over the past 2 weeks, how often have you been bothered by any of the following problems?
1. Little interest or pleasure in doing things ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
2. Feeling down, depressed, or hopeless ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

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 your baby's development, learning, or behavior? ☐ No ☐ Yes, describe:

_____

_____

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

- ☐ Smiles
- ☐ Coos
- ☐ Looks at you
- ☐ Comforts self (brings hands to mouth)
- ☐ Has different types of cries to show hunger or when tired
- ☐ Fusses if bored
- ☐ Moves both arms and legs together
- ☐ Holds head up when held
- ☐ Pushes head up when lying on tummy