



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.

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

- 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

Adapted with permission from "Efficient Identification of Adults with Depression and Dementia," September 15, 2004, American Family Physician. Copyright © 2004 American Academy of Family Physicians. All Rights Reserved.

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.

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



# American Academy of Pediatrics



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