



Bright Futures Previsit Questionnaire 4 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 Your Family Is Doing	<input type="checkbox"/> Taking time for yourself <input type="checkbox"/> Having time alone with your partner <input type="checkbox"/> Spending time alone with each of your children <input type="checkbox"/> Returning to work or school <input type="checkbox"/> What is good child care
Your Changing 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"/> How to calm your baby <input type="checkbox"/> Keeping daily routines
Feeding Your Baby	<input type="checkbox"/> Breastfeeding <input type="checkbox"/> Formula feeding <input type="checkbox"/> How your baby is growing <input type="checkbox"/> Starting solid foods <input type="checkbox"/> Food allergies <input type="checkbox"/> Your child's weight
Healthy Teeth	<input type="checkbox"/> Using a pacifier <input type="checkbox"/> Teething <input type="checkbox"/> Drooling <input type="checkbox"/> Not using a bottle in bed
Safety	<input type="checkbox"/> Car safety seats <input type="checkbox"/> Preventing falls, burns, and choking <input type="checkbox"/> Not using walkers <input type="checkbox"/> Drowning and pools <input type="checkbox"/> How to check for lead in your home <input type="checkbox"/> Checking the hot water heater temperature

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

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

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 learning, development, or behavior? No Yes, describe:

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

- | | |
|--|--|
| <input type="checkbox"/> Smiles to get your attention | <input type="checkbox"/> Likes to cuddle |
| <input type="checkbox"/> Keeps head steady when sitting up on your lap | <input type="checkbox"/> Lets you know when she likes something |
| <input type="checkbox"/> Begins to roll and reach for objects | <input type="checkbox"/> Lets you know when he does not like something |
| <input type="checkbox"/> Wants you to play | <input type="checkbox"/> Uses arms to lift chest |
| <input type="checkbox"/> Can calm down on his own | <input type="checkbox"/> Babbling |



American Academy
of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN™

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