CLEAR FORM

PATIENT NAME: _____ DATE: _____

Please print.

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.

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

PATIENT NAME: _____ DATE: _____

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4 MONTH VISIT

RISK ASSESSMENT

Anemia	Is your baby drinking anything other than breast milk or iron-fortified formula?	O No	O Yes	O Unsure
Hearing	Do you have concerns about how your baby hears?	O No	O Yes	O Unsure
Vision	Do you have concerns about how your baby sees?	O No	O Yes	O 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.	O No	O Yes
Family Relationships and Support		
Do you have someone to turn to when problems arise?	O Yes	O No
Have you and your partner been able to find time alone?	O Yes	O No
If you have other children, are you able to spend time with each of them alone? O NA	O Yes	O No
Have you returned to work or school or do you plan to do so?	O No	O Yes
If so, have you been able to find someone to care for your baby?	O Yes	O No
Do you get a daily report on your baby's activities from your caregiver? It may include feeding, elimination, sleep, and playtime.	O Yes	O No

CARING FOR YOUR BABY

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

HEALTHY TEETH

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

FEEDING YOUR BABY

General Information		
Are you feeding your baby anything other than breast milk or formula?	O No	O Yes
Are you comfortable waiting until your baby is about 6 months old to begin introducing solid foods?	O Yes	O No
Can you tell when your baby is hungry?	O Yes	O No
Can you tell when your baby is full?	O Yes	O No

PATIENT NAME: _____ DATE: _____

Please print.

4 MONTH VISIT

FEEDING YOUR BABY (*CONTINUED*)

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

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®

Patient Health Questionnaire (PHQ-9)

Patient Name: _____ **Date:** _____

	Not at all	Several days	More than half the days	Nearly every day
1. Over the *last 2 weeks,* how often have you been bothered by any of the following problems?	○	○	○	○
a. Little interest or pleasure in doing things	○	○	○	○
b. Feeling down, depressed, or hopeless	○	○	○	○
c. Trouble falling/staying asleep, sleeping too much	○	○	○	○
d. Feeling tired or having little energy	○	○	○	○
e. Poor appetite or overeating	○	○	○	○
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	○	○	○	○
g. Trouble concentrating on things, such as reading the newspaper or watching television.	○	○	○	○
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.	○	○	○	○
i. Thoughts that you would be better off dead or of hurting yourself in some way.	○	○	○	○

	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	○	○	○	○