



# Bright Futures Previsit Questionnaire

## 1 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"/> Feeling sad <input type="checkbox"/> Using drugs <input type="checkbox"/> Using alcohol <input type="checkbox"/> Smoking <input type="checkbox"/> Getting back to work or school <input type="checkbox"/> Breastfeeding plans <input type="checkbox"/> Choosing child care
<b>Your Baby and Family</b>	<input type="checkbox"/> Asking for help when you need it <input type="checkbox"/> Community services that may be able to help your family <input type="checkbox"/> Violence at home/abuse
<b>Getting to Know Your Baby</b>	<input type="checkbox"/> Sleep/wake schedules <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"/> Bored baby <input type="checkbox"/> Tummy time for playtime with you <input type="checkbox"/> How to calm your baby <input type="checkbox"/> Crying too much
<b>Feeding Your Baby</b>	<input type="checkbox"/> How often you should feed your baby <input type="checkbox"/> How to know your baby is getting enough <input type="checkbox"/> What to feed your baby <input type="checkbox"/> Formula feeding <input type="checkbox"/> Help with breastfeeding <input type="checkbox"/> How to hold your baby while feeding <input type="checkbox"/> Burping <input type="checkbox"/> Using a pacifier <input type="checkbox"/> Worry about your baby's weight
<b>Safety</b>	<input type="checkbox"/> Car safety seats <input type="checkbox"/> Preventing falls <input type="checkbox"/> Choking from bracelets, necklaces, and toys with loops or strings

### 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

<b>Vision</b>	Do you have concerns about how your child sees?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
<b>Tuberculosis</b>	Has a family member or contact had tuberculosis or a positive tuberculin skin test?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Was your child born in a country at high risk for tuberculosis (countries other than the United States, Canada, Australia, New Zealand, and Western Europe)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Has your child traveled (had contact with resident populations) for longer than 1 week to a country at high risk for tuberculosis?	<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? Describe:

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

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.

- If upset, able to calm    Recognizes parents' voices    Lifts head when on tummy  
 Follows parents with eyes    Smiles



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ACCOMPANIED BY/INFORMANT	PREFERRED LANGUAGE	DATE/TIME
DRUG ALLERGIES	CURRENT MEDICATIONS	
WEIGHT (%) <small>See growth chart.</small>	LENGTH (%)	WEIGHT FOR LENGTH (%)
		HEAD CIRC (%)

Name
ID NUMBER
TEMPERATURE
BIRTH DATE
AGE
<input type="checkbox"/> M <input type="checkbox"/> F

## History

<input type="checkbox"/> Previsit Questionnaire reviewed	Newborn screening <input type="checkbox"/> NL
<input type="checkbox"/> Child has special health care needs	Hearing screening <input type="checkbox"/> NL

Concerns and questions  None  Addressed (see other side)

Follow-up on previous concerns  None  Addressed (see other side)

Interval history  None  Addressed (see other side)

Medication Record reviewed and updated

## Social/Family History

See Initial History Questionnaire.  No interval change

**Family situation**

Parental adjustment to child \_\_\_\_\_

Maternal depression  Y  N \_\_\_\_\_

Observation of parent-child interaction \_\_\_\_\_

Reaction of siblings to new child \_\_\_\_\_

Work plans \_\_\_\_\_

Child care plans \_\_\_\_\_

## Review of Systems

See Initial History Questionnaire and Problem List.

No interval change

Changes since last visit \_\_\_\_\_

Nutrition:  Breast milk Minutes per feeding \_\_\_\_\_  
 Hours between feeding \_\_\_\_\_ Feedings per 24 hours \_\_\_\_\_  
 Problems with breastfeeding \_\_\_\_\_  
 Formula Ounces per feeding \_\_\_\_\_  
 Source of water: \_\_\_\_\_ Vitamins/Fluoride \_\_\_\_\_

Elimination:  NL \_\_\_\_\_

Sleep:  NL \_\_\_\_\_

Behavior:  NL \_\_\_\_\_

**Development** (if not reviewed in Previsit Questionnaire)

<input type="checkbox"/> SOCIAL-EMOTIONAL • If upset, able to calm	<input type="checkbox"/> COMMUNICATIVE • Recognizes parents' voices • Follows parent with eyes	<input type="checkbox"/> PHYSICAL DEVELOPMENT • Able to lift head when on tummy
<input type="checkbox"/> COGNITIVE • Has started to smile		

## Physical Examination

= NL

**Bright Futures Priority**

HEAD/FONTANELLE (positional skull deformities)

EYES (red reflex/strabismus/appears to see)

HEART  
 FEMORAL PULSES

ABDOMEN

MUSCULOSKELETAL (torticollis)  
 HIPS

NEUROLOGIC (tone, strength, symmetry)

**Additional Systems**

<input type="checkbox"/> GENERAL APPEARANCE	<input type="checkbox"/> EXTREMITIES
<input type="checkbox"/> EARS/APPEARS TO HEAR	<input type="checkbox"/> BACK
<input type="checkbox"/> NOSE	<input type="checkbox"/> SKIN
<input type="checkbox"/> MOUTH AND THROAT	
<input type="checkbox"/> LUNGS	
<input type="checkbox"/> GENITALIA <input type="checkbox"/> Male/Testes down <input type="checkbox"/> Female	

Abnormal findings and comments \_\_\_\_\_

## Assessment

Well child

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Anticipatory Guidance

<input type="checkbox"/> Discussed and/or handout given	<input type="checkbox"/> INFANT ADJUSTMENT	<input type="checkbox"/> SAFETY
<input type="checkbox"/> PARENTAL WELL-BEING	• Tummy time	• Car safety seat
<input type="checkbox"/> FAMILY ADJUSTMENT	• Encourage daily routines	• Falls
<input type="checkbox"/> FEEDING ROUTINES	• Back to sleep	• No strings around neck
• Breastfeeding (400 IU vitamin D supplement)	• Sleep location	• No shaking
• Iron-fortified formula	• Techniques to calm	• Smoke-free environment
• Solid foods (wait until 4–6 months)		
• Elimination <input type="checkbox"/> 5–8 wet diapers, 3–4 stools		

## Plan

Immunizations (See Vaccine Administration Record.)

Laboratory/Screening results \_\_\_\_\_

Referral to \_\_\_\_\_

**Follow-up/Next visit** \_\_\_\_\_

See other side

Print Name	Signature
PROVIDER 1	
PROVIDER 2	







# Bright Futures Parent Handout 1 Month Visit

Here are some suggestions from Bright Futures experts that may be of value to your family.

PARENTAL WELL-BEING

## How You Are Feeling

- Taking care of yourself gives you the energy to care for your baby. Remember to go for your postpartum checkup.
- Call for help if you feel sad or blue, or very tired for more than a few days.
- Know that returning to work or school is hard for many parents.
- Find safe, loving child care for your baby. You can ask us for help.
- If you plan to go back to work or school, start thinking about how you can keep breastfeeding.

INFANT ADJUSTMENT

## Getting to Know Your Baby

- Have simple routines each day for bathing, feeding, sleeping, and playing.
- Put your baby to sleep on his back.
  - In a crib, in your room, not in your bed.
  - In a crib that meets current safety standards, with no drop-side rail and slats no more than 2<sup>3</sup>/<sub>8</sub> inches apart. Find more information on the Consumer Product Safety Commission Web site at [www.cpsc.gov](http://www.cpsc.gov).
  - If your crib has a drop-side rail, keep it up and locked at all times. Contact the crib company to see if there is a device to keep the drop-side rail from falling down.
- Keep soft objects and loose bedding such as comforters, pillows, bumper pads, and toys out of the crib.
- Give your baby a pacifier if he wants it.
- Hold and cuddle your baby often.
  - Tummy time—put your baby on his tummy when awake and you are there to watch.
- Crying is normal and may increase when your baby is 6–8 weeks old.
- When your baby is crying, comfort him by talking, patting, stroking, and rocking.
- *Never shake your baby.*
- If you feel upset, put your baby in a safe place; call for help.

SAFETY

## Safety

- Use a rear-facing car safety seat in all vehicles.
- Never put your baby in the front seat of a vehicle with a passenger air bag.
- Always wear your seat belt and never drive after using alcohol or drugs.
- Keep your car and home smoke-free.
- Keep hanging cords or strings away from and necklaces and bracelets off of your baby.
- Keep a hand on your baby when changing clothes or the diaper.

FAMILY ADJUSTMENT

## Your Baby and Family

- Plan with your partner, friends, and family to have time for yourself.
- Take time with your partner too.
- Let us know if you are having any problems and cannot make ends meet. There are resources in our community that can help you.
- Join a new parents group or call us for help to connect to others if you feel alone and lonely.
- Call for help if you are ever hit or hurt by someone and if you and your baby are not safe at home.
- Prepare for an emergency/illness.
  - Keep a first-aid kit in your home.
  - Learn infant CPR.
  - Have a list of emergency phone numbers.
  - Know how to take your baby's temperature rectally. Call us if it is 100.4°F (38.0°C) or higher.
- Wash your hands often to help your baby stay healthy.

FEEDING ROUTINES

- Pat, rock, undress, or change the diaper to wake your baby to feed.
- Feed your baby when you see signs of hunger.
  - Putting hand to mouth
  - Sucking, rooting, and fussing
- End feeding when you see signs your baby is full.
  - Turning away
  - Closing the mouth
  - Relaxed arms and hands
- Breastfeed or bottle-feed 8–12 times per day.
- Burp your baby during natural feeding breaks.
- Having 5–8 wet diapers and 3–4 stools each day shows your baby is eating well.

## If Breastfeeding

- Continue to take your prenatal vitamins.
- When breastfeeding is going well (usually at 4–6 weeks), you can offer your baby a bottle or pacifier.

## If Formula Feeding

- Always prepare, heat, and store formula safely. If you need help, ask us.
- Feed your baby 2 oz every 2–3 hours. If your baby is still hungry, you can feed more.
- Hold your baby so you can look at each other.
- Do not prop the bottle.

## What to Expect at Your Baby's 2 Month Visit

### We will talk about

- Taking care of yourself and your family
- Sleep and crib safety
- Keeping your home safe for your baby
- Getting back to work or school and finding child care
- Feeding your baby

Poison Help: 1-800-222-1222

Child safety seat inspection:  
1-866-SEATCHECK; [seatcheck.org](http://seatcheck.org)



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