PATIENT NAME: _____ **DATE:** _____

Please print.

American Academy of Pediatrics

BRIGHT FUTURES PREVISIT QUESTIONNAIRE
2 MONTH VISIT

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 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.

- ☐ Smile back at you.
- ☐ Make sounds that let you know he is happy or upset.
- ☐ Make short cooing sounds.
- ☐ Move both arms and legs together.
- ☐ Hold her chin up when she is on her stomach.
- ☐ Open and shut his hands.

RISK ASSESSMENT

Vision	Do you have concerns about how your baby sees?	○ No	○ Yes	○ Unsure

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?	○ Yes	○ No
Are you having any problems using your car safety seat?	○ No	○ Yes
Is your water heater set so the temperature at the faucet is at or below 120°F/49°C?	○ Yes	○ No
Do you always stay within arm's reach whenever your baby is in or near water?	○ Yes	○ No
Do you have any questions about things you can do to keep your baby safe at home?	○ No	○ Yes
Safe Sleep		
Does your baby sleep on his back?	○ Yes	○ No
Does your baby sleep in a crib?	○ Yes	○ No
Does your baby sleep in your room?	○ Yes	○ No

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