PATIENT NAME: _____ **DATE:** _____

Please print.

American Academy of Pediatrics

BRIGHT FUTURES PREVISIT QUESTIONNAIRE
4 MONTH VISIT

Bright Futures™

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.

- ☐ 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.

RISK ASSESSMENT

Anemia	Is your baby drinking anything other than breast milk or iron-fortified formula?	○ No	○ Yes	○ Unsure
Hearing	Do you have concerns about how your baby hears?	○ No	○ Yes	○ Unsure
Vision	Do you have concerns about how your baby sees?	○ No	○ Yes	○ Unsure

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.	○ No	○ 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?	○ Yes	○ No
Do you have any questions about what to do when you baby outgrows his current 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 ever drink or carry hot liquids (such as tea or coffee) when holding your baby?	○ No	○ Yes
Do you always keep one hand on your baby when changing diapers or clothing on a changing table, couch, or bed?	○ Yes	○ No
Safe Sleep		
Do you have any difficulty getting your baby to sleep on his back?	○ No	○ Yes
Have you moved your crib mattress to the lowest position to prevent falls?	○ 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