American Academy of Pediatrics

BRIGHT FUTURES PREVISIT QUESTIONNAIRE
6 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.

- ☐ Pat or smile at his reflection.
- ☐ Look when you call her name.
- ☐ Babble.
- ☐ Roll over from his back to his tummy.
- ☐ Sit briefly without support.
- ☐ Make sounds such as "ga," "ma," and "ba."
- ☐ Pass a toy from one hand to another.
- ☐ Rake small objects with 4 fingers.
- ☐ Bang small objects on a surface.

RISK ASSESSMENT

Hearing	Do you have concerns about how your baby hears?	○ No	○ Yes	○ Unsure
Lead	Does your baby live in or visit a home or child care facility with an identified lead hazard or a home built before 1960 that is in poor repair or that was renovated in the past 6 months?	○ No	○ Yes	○ Unsure
Oral health	Does your baby's primary water source contain fluoride?	○ Yes	○ No	○ Unsure
Tuberculosis	Was your baby or any household member born in, or has he or she traveled to, a country where tuberculosis is common (this includes countries in Africa, Asia, Latin America, and Eastern Europe)?	○ No	○ Yes	○ Unsure
	Has your baby had close contact with a person who has tuberculosis disease or who has had a positive tuberculosis test result?	○ No	○ Yes	○ Unsure
	Is your baby infected with HIV?	○ No	○ Yes	○ Unsure
Vision	Do you have concerns about how your baby sees?	○ No	○ Yes	○ Unsure
	Do your baby's eyes appear unusual or seem to cross?	○ No	○ Yes	○ Unsure
	Do your baby's eyelids droop or does one eyelid tend to close?	○ No	○ Yes	○ Unsure
	Have your baby's eyes ever been injured?	○ No	○ Yes	○ Unsure

SAFETY

General Information		
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 with 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 have barriers around space heaters, woodstoves, and kerosene heaters?	○ Yes	○ No
Do you put a hat on your baby and apply sunscreen on her when you go outside?	○ Yes	○ No
Do you keep household cleaners, chemicals, and medicines locked up and out of your baby's sight and reach?	○ Yes	○ No
Do you always stay within arm's reach of your baby when he is in the bath?	○ Yes	○ No
Do you always keep one hand on your baby when changing diapers or clothing on a changing table, couch, or bed?	○ Yes	○ No
Do you have a gate at the top and bottom of all stairs in your home?	○ Yes	○ No
Safe Sleep		
Do you continue to place your baby onto her back for sleep?	○ Yes	○ No
Does your baby sleep in a crib?	○ 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