PATIENT NAME: _____ **DATE:** _____

Please print.

American Academy of Pediatrics

BRIGHT FUTURES PREVISIT QUESTIONNAIRE
9 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 have special health care needs? ○ **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.

- ☐ Use basic gestures, such as holding her arms out to be picked up or waving "bye-bye."
- ☐ Look for dropped objects.
- ☐ Play games such as peekaboo and pat-a-cake.
- ☐ Turn consistently when his name is called.
- ☐ Say, "Dada" or "Mama."
- ☐ Look around when you say things such as "Where's your bottle?" and "Where's your blanket?"
- ☐ Copy sounds that you make.
- ☐ Sit well without support.
- ☐ Pull herself to a standing position.
- ☐ Move easily between sitting and lying.
- ☐ Crawl on hands and knees.
- ☐ Pick up food and eat it.
- ☐ Pick up small objects with 3 fingers and a thumb.
- ☐ Let go of objects on purpose.
- ☐ Bang objects together.

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
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

CARING FOR YOUR BABY

Do you have a regular bedtime routine for your baby?	O Yes	O No
Does she wake up during the night?	O No	O Yes
Is your baby learning new things?	O Yes	O No
Does your baby have ways to tell you what he wants and needs?	O Yes	O No
Is a TV, computer, tablet, or smartphone on in the background while 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
Have you made a family media use plan to help you balance media use with other family activities?	O Yes	O No

SAFETY

Car and Home Safety		
Is your baby fastened securely in a rear-facing car safety seat in the back seat every time he rides in a vehicle?	O Yes	O No
Do you have any habits or reminders that prevent you from ever leaving your baby in the car?	O Yes	O No
Do you keep your baby away from the stove, fireplaces, and space heaters?	O Yes	O No
Do you keep cleaners and medicines locked up and out of your baby's sight and reach?	O Yes	O No
Do you always stay within arm's reach of your baby when she is in the bathtub?	O Yes	O No
Do you keep furniture away from windows and use operable window guards on second-floor and higher windows? (Operable means that, in case of an emergency, an adult can open the window.)	O Yes	O No
Do you have a gate at the top and bottom of all stairs in your home?	O Yes	O No
Gun Safety		
Does anyone in your home or the homes where your baby spends time have a gun?	O No	O Yes
If yes, is the gun unloaded and locked up?	O Yes	O No
If yes, is the ammunition stored and locked up separately from the gun?	O Yes	O No