PATIENT NAME: _____ **DATE:** _____

Please print.

American Academy of Pediatrics

BRIGHT FUTURES PREVISIT QUESTIONNAIRE
FIRST WEEK VISIT (3 TO 5 DAYS)

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:

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.

- ☐ Stay awake for a short time to feed.
- ☐ Make brief eye contact with an adult when held.
- ☐ Cry when she is uncomfortable.
- ☐ Calm to an adult's voice.
- ☐ Lift and turn his head to the side briefly when he is on his tummy.
- ☐ Move her arms and legs at the same time when startled.
- ☐ Keep his hands in a fist.

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 with your car safety seat?	○ No	○ Yes
Have you started developing habits that will help prevent you from ever forgetting your baby in the car?	○ Yes	○ No
Is your water heater set so the temperature at the faucet is at or below 120°F/49°C?	○ Yes	○ No
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