



BRIGHT FUTURES PREVISIT QUESTIONNAIRE

9 MONTH VISIT

To provide you and your baby with the best possible health care, we would like to know how things are going. Please answer all the questions. **Child Development screening and Oral Health Risk Assessment are also part of this visit.** Thank you.

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 there been major changes lately in your baby's or family's life? 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.

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

9 MONTH VISIT

RISK ASSESSMENT

Hearing	Do you have concerns about how your baby hears?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> 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?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
Oral health	Does your baby's primary water source contain fluoride?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unsure
Vision	Do you have concerns about how your baby sees?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Do your baby's eyes appear unusual or seem to cross?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Do your baby's eyelids droop or does one eyelid tend to close?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
	Have your baby's eyes ever been injured?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure

ANTICIPATORY GUIDANCE

How are things going for you, your baby, and your family?

YOUR FAMILY'S HEALTH AND WELL-BEING

Do you always feel safe in your home?	<input type="radio"/> Yes	<input type="radio"/> No
Has your partner, or another significant person in your life, ever hit, kicked, or shoved you, or physically hurt you or the baby?	<input type="radio"/> No	<input type="radio"/> Yes
Have you developed routines or other ways to take care of yourself?	<input type="radio"/> Yes	<input type="radio"/> No

CARING FOR YOUR BABY

Do you have a regular bedtime routine for your baby?	<input type="radio"/> Yes	<input type="radio"/> No
Does she wake up during the night?	<input type="radio"/> No	<input type="radio"/> Yes
Is your baby learning new things?	<input type="radio"/> Yes	<input type="radio"/> No
Does your baby have ways to tell you what he wants and needs?	<input type="radio"/> Yes	<input type="radio"/> No
Is a TV, computer, tablet, or smartphone on in the background while your baby is in the room?	<input type="radio"/> No	<input type="radio"/> Yes
Does your baby watch TV or play on a tablet or smartphone? If yes, how much time each day? _____ hours	<input type="radio"/> No	<input type="radio"/> Yes
Have you made a family media use plan to help you balance media use with other family activities?	<input type="radio"/> Yes	<input type="radio"/> No

DISCIPLINE

Do you and your partner agree on how to handle your baby's behavior?	<input type="radio"/> Yes	<input type="radio"/> No
Do you limit the use of "No" to only the most important issues?	<input type="radio"/> Yes	<input type="radio"/> No
If you have other children, do you let them help with the baby as much as they can?	<input type="radio"/> NA	<input type="radio"/> Yes <input type="radio"/> No

FEEDING YOUR BABY

Does your baby feed herself?	<input type="radio"/> Yes	<input type="radio"/> No
Does your baby drink from a cup?	<input type="radio"/> Yes	<input type="radio"/> No
Do you let your baby decide what and how much to eat?	<input type="radio"/> Yes	<input type="radio"/> No
Do you give your baby foods with different textures (such as pureed, blended, mashed, chopped, or lumps)?	<input type="radio"/> Yes	<input type="radio"/> No
If you are breastfeeding, are you planning on continuing?	<input type="radio"/> NA	<input type="radio"/> Yes <input type="radio"/> 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?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have any habits or reminders that prevent you from ever leaving your baby in the car?	<input type="radio"/> Yes	<input type="radio"/> No
Do you keep your baby away from the stove, fireplaces, and space heaters?	<input type="radio"/> Yes	<input type="radio"/> No

Please print.

9 MONTH VISIT

SAFETY (CONTINUED)

Car and Home Safety (continued)		
Do you keep cleaners and medicines locked up and out of your baby's sight and reach?	<input type="radio"/> Yes	<input type="radio"/> No
Do you always stay within arm's reach of your baby when she is in the bathtub?	<input type="radio"/> Yes	<input type="radio"/> 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.)	<input type="radio"/> Yes	<input type="radio"/> No
Do you have a gate at the top and bottom of all stairs in your home?	<input type="radio"/> Yes	<input type="radio"/> No
Gun Safety		
Does anyone in your home or the homes where your baby spends time have a gun?	<input type="radio"/> No	<input type="radio"/> Yes
If yes, is the gun unloaded and locked up?	<input type="radio"/> Yes	<input type="radio"/> No
If yes, is the ammunition stored and locked up separately from the gun?	<input type="radio"/> Yes	<input type="radio"/> No

Consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, 4th Edition

For more information, go to <https://brightfutures.aap.org>.

American Academy of Pediatrics

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The information contained in this questionnaire should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances. Original questionnaire included as part of the *Bright Futures Tool and Resource Kit*, 2nd Edition.

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