Barrow Pediatrics
and Adolescent Medicine

Please Follow These Instructions and Bring the Completed Form to Your Visit:

You can: 1) Use a Computer to complete your answers; or 2) Print out a blank form and use a pen to complete your answers. For those with access to a Computer, Option #1 will be the easiest method.

Option #1: Complete the Form using a Computer:

1. Open the downloaded PDF file and complete the Well-Check form using your Computer.
2. **Save all changes.** *You will lose your work* if you do not save your changes before printing out the completed form.
3. Print out the completed Well-Check form as a one-sided document on front-side of pages.
4. Bring the completed, printed form to our office at your appointment time.
5. Give the completed form to our receptionist.

Option #2: Print Out a Blank Form and use a pen to complete your answers.

1. Open the downloaded PDF file and print out a blank Well-Check form as a one-sided document on front-side of pages.
2. Complete the Well-Check form using a pen.
3. Bring the completed, printed form to our office at your appointment time.
4. Give the completed form to our receptionist.

NOTE: Parents of 11-12 year olds, 13-14 year olds, and 15-17 year olds have a separate Parent Well-Check form to complete for your child. This additional form is included in the downloaded PDF form file.

Thank You for Completing Your Child's Well-Check Form in Advance!

This will help reduce the wait time spent at your child's office visit.

CLEAR FORM

PATIENT NAME: _____ DATE: _____

Please print.

American Academy of Pediatrics

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

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. 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 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.

- ☐ 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.

PATIENT NAME: _____ DATE: _____

Please print.

FIRST WEEK VISIT (3 TO 5 DAYS)

RISK ASSESSMENT

Vision	Do you have concerns about how your baby sees?	O No	O Yes	O Unsure

ANTICIPATORY GUIDANCE

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

YOUR FAMILY'S HEALTH AND WELL-BEING

Living Situation and Food Security		
Is permanent housing a worry for you?	O No	O Yes
Do you have the things you need to take care of your baby, such as a crib, a car safety seat, and diapers?	O Yes	O No
Does your home have enough heat, hot water, and electricity?	O Yes	O No
Do you have health insurance for yourself?	O Yes	O No
Within the past 12 months, were you ever worried whether your food would run out before you got money to buy more?	O No	O Yes
Within the past 12 months, did the food you bought not last, and you did not have money to get more?	O No	O Yes
Do you need help in finding community support services, such as WIC or food stamps?	O No	O Yes
Family Support		
Do you search the Internet to learn about how to care for your baby?	O No	O Yes

GETTING TO KNOW YOUR BABY

How You Are Feeling			
Do you sleep when the baby sleeps?		O Yes	O No
Does your partner or do other family members help with the baby?		O Yes	O No
If you have other children, are you able to spend time with them?	O NA	O Yes	O No

CARING FOR YOUR BABY

Do you read to your baby?	O Yes	O No
Is a TV, computer, tablet, or smartphone on in the background when your baby is in the room?	O No	O Yes
Is your baby able to fully awaken for feedings?	O Yes	O No
Do you have questions about how to calm your baby?	O No	O Yes
When to Call Your Doctor/Emergency Planning		
Do you know how to take your baby's temperature rectally?	O Yes	O No
Do you have a list of emergency phone numbers?	O Yes	O No
Do you have any questions about taking your baby out in public places?	O No	O Yes

FEEDING YOUR BABY

General Information		
Does your baby feed well?	O Yes	O No
Do you have any questions about how your baby is growing?	O No	O Yes
Are you having problems burping your baby?	O Yes	O No
Can you tell when your baby is hungry?	O Yes	O No
Can you tell when your baby is full?	O Yes	O No
Does your baby have 5 or 6 wet disposable diapers (or 6–8 cloth diapers) and 3 or 4 stools a day?	O Yes	O No

PATIENT NAME: _____ DATE: _____

Please print.

FIRST WEEK VISIT (3 TO 5 DAYS)

FEEDING YOUR BABY (*CONTINUED*)

If you are breastfeeding, answer these questions.		
Is breastfeeding uncomfortable or painful?	O No	O Yes
Do you eat foods that are high in protein (such as eggs, lean meat, poultry, fish, or beans) every day?	O Yes	O No
Are you continuing to take prenatal vitamins?	O Yes	O No
Do you take medications (either over-the-counter or prescription) or herbal supplements?	O No	O Yes
Are you giving your baby vitamin D drops?	O Yes	O No
If you are formula feeding, or providing formula supplementation, answer these questions.		
Are you using iron-fortified formula?	O Yes	O No
Do you have any questions about using formula, such as how much it costs or how to prepare it?	O No	O 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?	O Yes	O No
Are you having any problems with your car safety seat?	O No	O Yes
Have you started developing habits that will help prevent you from ever forgetting your baby in the car?	O Yes	O No
Is your water heater set so the temperature at the faucet is at or below 120°F/49°C?	O Yes	O No
Safe Sleep		
Does your baby sleep on his back?	O Yes	O No
Does your baby sleep in a crib?	O Yes	O No
Does your baby sleep in your room?	O Yes	O 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

DEDICATED TO THE HEALTH OF ALL CHILDREN®