



# 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.



# BRIGHT FUTURES PREVISIT QUESTIONNAIRE

## 4 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. **Maternal Depression screening is 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"/> Laugh out loud.                                     | <input type="checkbox"/> Turn toward voices.  | <input type="checkbox"/> Roll over from his tummy to his back. |
| <input type="checkbox"/> Look for you or another caregiver when he is upset. | <input type="checkbox"/> Make extended cooing sounds.                                       | <input type="checkbox"/> Keep her hands open, not in a fist.   |
|  | <input type="checkbox"/> Support herself on her elbows and wrists when she is on her tummy. | <input type="checkbox"/> Play with his fingers.                |
|  |   | <input type="checkbox"/> Grasp objects.                        |

## 4 MONTH VISIT

### RISK ASSESSMENT

<b>Anemia</b>	Is your baby drinking anything other than breast milk or iron-fortified formula?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
<b>Hearing</b>	Do you have concerns about how your baby hears?	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> Unsure
<b>Vision</b>	Do you have concerns about how your baby sees?	<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

<b>Living Situation</b>					
Are you or is anyone else in your household exposed to harmful substances, such as lead? This may occur in a work environment such as construction, farming, or factory work.				<input type="radio"/> No	<input type="radio"/> Yes
<b>Family Relationships and Support</b>					
Do you have someone to turn to when problems arise?				<input type="radio"/> Yes	<input type="radio"/> No
Have you and your partner been able to find time alone?				<input type="radio"/> Yes	<input type="radio"/> No
If you have other children, are you able to spend time with each of them alone?			<input type="radio"/> NA	<input type="radio"/> Yes	<input type="radio"/> No
Have you returned to work or school or do you plan to do so?				<input type="radio"/> No	<input type="radio"/> Yes
If so, have you been able to find someone to care for your baby?				<input type="radio"/> Yes	<input type="radio"/> No
Do you get a daily report on your baby's activities from your caregiver? It may include feeding, elimination, sleep, and playtime.				<input type="radio"/> Yes	<input type="radio"/> No

#### CARING FOR YOUR BABY

<b>Your Changing Baby</b>					
Are you able to calm your baby when he is crying?				<input type="radio"/> Yes	<input type="radio"/> No
Are you ever afraid that you or other caregivers may hurt the baby?				<input type="radio"/> No	<input type="radio"/> Yes
Are you beginning to understand your baby's likes and dislikes?				<input type="radio"/> Yes	<input type="radio"/> No
Do you have a daily routine for feedings, naps, and bedtime?				<input type="radio"/> Yes	<input type="radio"/> No
Is a TV, computer, tablet, or smartphone on in the background when 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
Do you put your baby on her tummy for short periods of time when she is awake and with you?				<input type="radio"/> Yes	<input type="radio"/> No
Do you and your baby enjoy quiet activities, such as reading, singing, or taking walks outside?				<input type="radio"/> Yes	<input type="radio"/> No

#### HEALTHY TEETH

<b>Taking Care of Your Teeth</b>					
Do you regularly see a dentist and brush and floss your teeth?				<input type="radio"/> Yes	<input type="radio"/> No
<b>Taking Care of Your Baby's Teeth</b>					
Is your baby showing signs of teething, such as drooling?				<input type="radio"/> No	<input type="radio"/> Yes
Do you let your baby have a bottle in the crib?				<input type="radio"/> No	<input type="radio"/> Yes
Do you have any questions about how to clean your baby's gums or teeth?				<input type="radio"/> No	<input type="radio"/> Yes

#### FEEDING YOUR BABY

<b>General Information</b>					
Are you feeding your baby anything other than breast milk or formula?				<input type="radio"/> No	<input type="radio"/> Yes
Are you comfortable waiting until your baby is about 6 months old to begin introducing solid foods?				<input type="radio"/> Yes	<input type="radio"/> No
Can you tell when your baby is hungry?				<input type="radio"/> Yes	<input type="radio"/> No
Can you tell when your baby is full?				<input type="radio"/> Yes	<input type="radio"/> No

Please print.

## 4 MONTH VISIT

### FEEDING YOUR BABY (CONTINUED)

If you are breastfeeding, answer these questions.		
Are you still giving your baby vitamin D drops?	<input type="radio"/> Yes	<input type="radio"/> No
Do you take any supplements, herbs, vitamins, or medications?	<input type="radio"/> No	<input type="radio"/> Yes
Do you have questions about pumping and storing your breast milk?	<input type="radio"/> No	<input type="radio"/> Yes
If you are formula feeding, or providing formula supplementation, answer these questions.		
Are you using iron-fortified formula?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have questions about using formula, such as how much it costs or how to prepare it?	<input type="radio"/> No	<input type="radio"/> 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?	<input type="radio"/> Yes	<input type="radio"/> No
Do you have any questions about what to do when your baby outgrows his current car safety seat?	<input type="radio"/> No	<input type="radio"/> Yes
Is your water heater set so the temperature at the faucet is at or below 120°F/49°C?	<input type="radio"/> Yes	<input type="radio"/> No
Do you ever drink or carry hot liquids (such as tea or coffee) when holding your baby?	<input type="radio"/> No	<input type="radio"/> Yes
Do you always keep one hand on your baby when changing diapers or clothing on a changing table, couch, or bed?	<input type="radio"/> Yes	<input type="radio"/> No
Safe Sleep		
Do you have any difficulty getting your baby to sleep on his back?	<input type="radio"/> No	<input type="radio"/> Yes
Have you moved your crib mattress to the lowest position to prevent falls?	<input type="radio"/> Yes	<input type="radio"/> No
Does your baby sleep in your room?	<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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