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
6 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 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.

- ☐ Pat or smile at his reflection.
- ☐ Look when you call her name.
- ☐ Babble.
- ☐ Roll over from his back to his tummy.
- ☐ Sit briefly without support.
- ☐ Make sounds such as "ga," "ma," and "ba."
- ☐ Pass a toy from one hand to another.
- ☐ Rake small objects with 4 fingers.
- ☐ Bang small objects on a surface.

PATIENT NAME: _____ DATE: _____

Please print.

6 MONTH VISIT

RISK ASSESSMENT

Hearing	Do you have concerns about how your baby hears?	O No	O Yes	O 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?	O No	O Yes	O Unsure
Oral health	Does your baby's primary water source contain fluoride?	O Yes	O No	O Unsure
Tuberculosis	Was your baby or any household member born in, or has he or she traveled to, a country where tuberculosis is common (this includes countries in Africa, Asia, Latin America, and Eastern Europe)?	O No	O Yes	O Unsure
	Has your baby had close contact with a person who has tuberculosis disease or who has had a positive tuberculosis test result?	O No	O Yes	O Unsure
	Is your baby infected with HIV?	O No	O Yes	O Unsure
Vision	Do you have concerns about how your baby sees?	O No	O Yes	O Unsure
	Do your baby's eyes appear unusual or seem to cross?	O No	O Yes	O Unsure
	Do your baby's eyelids droop or does one eyelid tend to close?	O No	O Yes	O Unsure
	Have your baby's eyes ever been injured?	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 the baby, such as a crib, a car safety seat, and diapers?	O Yes	O No
Does your home have enough heat, hot water, electricity, and working appliances?	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
Alcohol and Drugs		
Does anyone in your household drink beer, wine, or liquor?	O No	O Yes
Do you or other family members use marijuana, cocaine, pain pills, narcotics, or other controlled substances?	O No	O Yes
Family Relationships and Support		
Do you have people you can go to when you need help with your family?	O Yes	O No
Do you have child care or a reliable person to care for your baby?	O Yes	O No

CARING FOR YOUR BABY

Your Baby's Development		
Is your baby learning new things?	O Yes	O No
Is your baby adapting to new situations, people, and places?	O Yes	O No
Does your baby have ways to tell you what he wants and needs?	O Yes	O No
Does your baby respond when you look at books together?	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
Does your baby have a regular daily schedule for feeding, napping, playing, and sleeping?	O Yes	O No
Is your baby learning to go to sleep by himself?	O Yes	O No
Can your baby calm herself?	O Yes	O No
Do you have ways to help your baby calm himself if he cannot do it himself?	O Yes	O No

PATIENT NAME: _____ DATE: _____

Please print.

6 MONTH VISIT

HEALTHY TEETH

Do you give your baby a bottle in her crib?	O No	O Yes

FEEDING YOUR BABY

General Information		
What are you feeding your baby? Check all that apply: _____ Breast milk _____ Formula _____ Both		
Are you feeding your baby any drinks or foods besides breast milk or formula? Check all that apply: ____ Water ____ Juice ____ Cereal ____ Meats ____ Fruits ____ Vegetables ____ Other foods		
Does your baby let you know when he likes or dislikes new foods that you have introduced?	O Yes	O No
Do you wash vegetables and fruits before serving them to your baby and family?	O Yes	O No
If you are breastfeeding, answer these questions.		
Are you planning on continuing?	O NA	O Yes O No
Do you have questions about pumping and storing your breast milk?	O No	O Yes
Are you still giving your baby vitamin D drops and iron 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 or concerns about the formula, such as how much it costs or how to prepare it?	O No	O Yes

SAFETY

General Information		
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
Is your water heater set so the temperature at the faucet is at or below 120°F/49°C?	O Yes	O No
Do you have barriers around space heaters, woodstoves, and kerosene heaters?	O Yes	O No
Do you put a hat on your baby and apply sunscreen on her when you go outside?	O Yes	O No
Do you keep household cleaners, chemicals, 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 he is in the bath?	O Yes	O No
Do you always keep one hand on your baby when changing diapers or clothing on a changing table, couch, or bed?	O Yes	O No
Do you have a gate at the top and bottom of all stairs in your home?	O Yes	O No
Safe Sleep		
Do you continue to place your baby onto her back for sleep?	O Yes	O No
Does your baby sleep in a crib?	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®