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
# 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.**

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

PATIENT NAME: _____ DATE: _____

Please print.

# 9 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 |
| **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

| | | |
|---|---|---|
| Do you always feel safe in your home? | O Yes | O No |
| Has your partner, or another significant person in your life, ever hit, kicked, or shoved you, or physically hurt you or the baby? | O No | O Yes |
| Have you developed routines or other ways to take care of yourself? | O Yes | O No |

### CARING FOR YOUR BABY

| | | |
|---|---|---|
| Do you have a regular bedtime routine for your baby? | O Yes | O No |
| Does she wake up during the night? | O No | O Yes |
| Is your baby learning new things? | O Yes | O No |
| Does your baby have ways to tell you what he wants and needs? | 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?<br>If yes, how much time each day? _____hours | O No | O Yes |
| Have you made a family media use plan to help you balance media use with other family activities? | O Yes | O No |

### DISCIPLINE

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

### FEEDING YOUR BABY

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

PATIENT NAME: _____ DATE: _____

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? | ○ Yes | ○ No |
| Do you always stay within arm's reach of your baby when she is in the bathtub? | ○ Yes | ○ 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.) | ○ Yes | ○ No |
| Do you have a gate at the top and bottom of all stairs in your home? | ○ Yes | ○ No |
| **Gun Safety** | | |
| Does anyone in your home or the homes where your baby spends time have a gun? | ○ No | ○ Yes |
| If yes, is the gun unloaded and locked up? | ○ Yes | ○ No |
| If yes, is the ammunition stored and locked up separately from the gun? | ○ Yes | ○ 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®