Bright Futures.

Bright Futures Previsit Questionnaire
9 Month Visit

For us to provide you and your baby with the best possible health care, we would like to know how things are going.
Please answer all of 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?

We are interested in answering your questions. Please check off the boxes for the topics you would like to discuss the most today.

Your Baby and Family	☐ Having time alone for yourself ☐ Having time alone with your partner ☐ Feeling safe in your home ☐ Your family's ideas about how your baby should act ☐ Your baby's behavior
Your Changing and Developing Baby	☐ How your baby is learning ☐ Games and toys that help your baby learn ☐ Your baby's nighttime routine ☐ Waking up at night ☐ Crying with new people
Feeding Your Baby	☐ Baby feeding himself ☐ Adding solid and table food ☐ Increasing the thickness of foods ☐ Using a cup ☐ Continuing breastfeeding and formula-feeding ☐ Your baby's weight
Safety	☐ Keeping your home safe with an active baby ☐ Car safety seats ☐ Preventing burns, falls, and poisoning ☐ Gun safety ☐ Water and bathtub safety

Questions About Your Baby

Have any of your baby's relatives developed new medical problems since your last visit? If yes, please describe: ☐ Yes ☐ No ☐ Unsure

Hearing	Do you have concerns about how your child hears?	☐ Yes	☐ No	☐ Unsure
Vision	Do you have concerns about how your child sees?	☐ Yes	☐ No	☐ Unsure
	Do your child's eyes appear unusual or seem to cross, drift, or be lazy?	☐ Yes	☐ No	☐ Unsure
	Do your child's eyelids droop or does one eyelid tend to close?	☐ Yes	☐ No	☐ Unsure
	Have your child's eyes ever been injured?	☐ Yes	☐ No	☐ Unsure
Oral Health	Are cavities a problem for you or anyone else in your family?	☐ Yes	☐ No	☐ Unsure
	Does your child sleep with a bottle?	☐ Yes	☐ No	☐ Unsure
	Does your child continuously breastfeed through the night?	☐ Yes	☐ No	☐ Unsure
Lead	Does your child have a sibling or playmate who has or had lead poisoning?	☐ Yes	☐ No	☐ Unsure
	Does your child live in or regularly visit a house or child care facility built before 1978 that is being or has recently been (within the past 6 months) renovated or remodeled?	☐ Yes	☐ No	☐ Unsure
	Does your child live in or regularly visit a house or child care facility built before 1950?	☐ Yes	☐ No	☐ Unsure

Does your child have any special health care needs? ☐ No ☐ Yes, describe:

Have there been any major changes in your family lately? ☐ Move ☐ Job change ☐ Separation ☐ Divorce ☐ Death in the family ☐ Any other changes?

Does your child live with anyone who uses tobacco or spend time in any place where people smoke? ☐ No ☐ Yes

Your Growing and Developing Baby

Do you have specific concerns about your baby's learning, development, or behavior? ☐ No ☐ Yes, describe:

Check off each of the tasks that your baby is able to do.

- ☐ Looks for something that has been dropped
- ☐ Pulls to stand
- ☐ Is afraid of new people
- ☐ Goes to you to play and be comforted
- ☐ Points things out
- ☐ Sits well
- ☐ Can repeat sounds
- ☐ Looks at books
- ☐ Crawls
- ☐ Plays peekaboo

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Bright Futures Parent Supplemental Questionnaire
9 Month Visit

For us to provide you and your baby with the best possible health care, we would like to know how things are going.
Please circle Yes or No for each question. Thank you.

Your Baby and Family: Family Adaptations

Do you and your partner agree on how to raise your baby?		Yes	No
Do you limit when you say "No" to your baby to only the most important issues?		Yes	No
Do you and other caregivers have the same idea about what behavior is OK for your baby?		Yes	No
If you have other children, do they help with the baby as much as they can?	N/A	Yes	No
Do you have someone who you can trust to look after your baby?		Yes	No
Do you make time for yourself?		Yes	No
Do you always feel safe in your home?		Yes	No
Has your partner ever hurt you or your baby?		No	Yes
Are you scared that other people may hurt your baby?		No	Yes

Your Changing and Developing Baby: Infant Independence

Do you have a regular bedtime routine for your baby?	Yes	No
Do you let your baby fall asleep on his own?	Yes	No
Do you watch your baby while she is playing?	Yes	No
Does your baby try to do things like you?	Yes	No
After your baby watches you hide a toy, can he find it?	Yes	No
Does your baby play actively for one hour or more a day?	Yes	No
How many hours per day does your baby watch TV?	_____ hours	

Feeding Your Baby: Feeding Routine

Do you feed your baby many types of vegetables?	Yes	No
Do you let your baby decide what and how much to eat?	Yes	No
Do you give your baby foods with different textures (pureed, blended, mashed, chopped, lumps)?	Yes	No
Can your baby drink from a cup?	Yes	No
Can your baby feed herself?	Yes	No

Safety

Do you always use a car safety seat?		Yes	No
Is your baby's car safety seat always rear-facing in the back seat of the car?		Yes	No
Are you having any problems with your car safety seat?		No	Yes
Do you keep your baby away from heaters and fires?		Yes	No
Do you always stay close enough to touch your baby when he is in the bathtub?		Yes	No
Do you keep furniture away from windows and use window guards for second floor and higher windows?		Yes	No
Do you keep cleaners and medicines locked up?		Yes	No
Does anyone in your home or the homes where your baby spends time have a gun?		No	Yes
If so, are the guns unloaded and locked away?	N/A	Yes	No
Does anyone smoke around your baby?		No	Yes
If you smoke, would you like information on how to stop?		Yes	No

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Bright Futures Medical Screening Questionnaire
9 Month Visit

Please answer the following questions about your child's health by circling Y, N, or Unsure.

Do you have concerns about how your child hears?	Y	N	Unsure
Do you have concerns about how your child sees?	Y	N	Unsure
Do your child's eyes appear unusual or seem to cross, drift, or be lazy?	Y	N	Unsure
Do your child's eyelids droop or does one eyelid tend to close?	Y	N	Unsure
Have your child's eyes ever been injured?	Y	N	Unsure
Does your child have a sibling or playmate who has or had lead poisoning?	Y	N	Unsure
Does your child live in or regularly visit a house or child care facility built before 1978 that is being or has recently been (within the last 6 months) renovated or remodeled?	Y	N	Unsure
Does your child live in or regularly visit a house or child care facility built before 1950?	Y	N	Unsure
Are cavities a problem for you or anyone else in your family?	Y	N	Unsure
Does your child sleep with a bottle?	Y	N	Unsure
Does your child continuously breastfeed through the night?	Y	N	Unsure

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American Academy of Pediatrics

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