Child Name: _____

Bright Futures Previsit Questionnaire
2 to 5 Day (First Week) 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.

How You Are Feeling	☐ Your health ☐ Feeling sad ☐ Family stress ☐ Unwanted advice ☐ Starting a daily routine
Getting Used to Your Baby	☐ How you are doing with your baby ☐ Calming your baby ☐ Crib safety ☐ Where your baby sleeps ☐ How your baby sleeps ☐ Placing baby on back to sleep
Feeding Your Baby	☐ Gaining weight ☐ How your baby shows if he/she is hungry or full ☐ Drinking enough ☐ Jaundice (skin is yellow) ☐ Burping ☐ Breastfeeding ☐ Formula
Safety	☐ Car safety seat ☐ Cigarette smoke ☐ Water heater temperature
Baby Care	☐ When to call the doctor's office ☐ Taking your baby's temperature ☐ Not getting sick ☐ Hand washing ☐ Emergency situations ☐ Leaving the house ☐ Skin care ☐ Sunburns

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

_____

_____

Vision	Do you have concerns about how your child sees?	☐ Yes	☐ No	☐ Unsure

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

_____

_____

Other than your baby's birth, have there been any major changes in your family lately?
☐ Move ☐ Job change ☐ Separation ☐ Divorce ☐ Death in the family ☐ Any other changes? Describe:

_____

_____

Over the past 2 weeks, how often have you been bothered by any of the following problems?
1. Little interest or pleasure in doing things ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
2. Feeling down, depressed, or hopeless ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

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 how your baby is growing, learning, or acting? ☐ No ☐ Yes, describe:

_____

_____

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

☐ Eats well
☐ Turns and calms to your voice
☐ Follows your face
☐ Can suck, swallow, and breathe easily

Bright Futures™ prevention and health promotion for infants, children, adolescents, and their families™

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

*** CONTINUE TO BACK FOR IMPORTANT HEALTH AND SAFETY QUESTIONS ***

Westerville Pediatric Specialists, Inc.

Child Name: _____

The questions below are to be answered by PARENT/LEGAL GUARDIAN.

HEALTH AND SAFETY

We are devoted to the health and safety of you and your family. Please tell us how comfortable you feel with the following necessities:

I have enough **MONEY** to provide for my family.

Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly Agree
☐	☐	☐	☐	☐

I am able to provide **FOOD** for my family.

Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly Agree
☐	☐	☐	☐	☐

I am able to provide **HOUSING** for my family.

Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly Agree
☐	☐	☐	☐	☐

I am able to provide or arrange **TRANSPORTATION** for my family.

Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly Agree
☐	☐	☐	☐	☐