Child Name: _____

Bright Futures Previsit Questionnaire
6 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.

How Your Family Is Doing	☐ Being a good parent and partner ☐ Where to go when you need help ☐ Finding good child care ☐ Finding and joining playgroups
Your Baby's Development	☐ How your baby learns ☐ How your baby can calm down alone ☐ How to keep your baby safe while sleeping ☐ Bedtime routines ☐ Your baby falling asleep on his own ☐ Your child's weight
Feeding Your Baby	☐ Starting solid food ☐ How to add new foods ☐ How much food your baby should eat ☐ Drinking from a cup ☐ Staying on breast milk or formula ☐ Food allergies
Healthy Teeth	☐ Brushing your baby's teeth ☐ Need for fluoride supplements
Safety	☐ Keeping your home safe with a crawling baby ☐ Car safety seats ☐ Preventing burns, falls, choking, and poisoning ☐ Bathtub and water 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
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
Tuberculosis	Was your child born in a country at high risk for tuberculosis (countries other than the United States, Canada, Australia, New Zealand, or Western Europe)?	☐ Yes	☐ No	☐ Unsure
	Has your child traveled (had contact with resident populations) for longer than 1 week to a country at high risk for tuberculosis?	☐ Yes	☐ No	☐ Unsure
	Has a family member or contact had tuberculosis or a positive tuberculin skin test?	☐ Yes	☐ No	☐ Unsure
	Is your child infected with HIV?	☐ 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

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?

_____

_____

_____

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 your baby's learning, development, or behavior? ☐ No ☐ Yes, describe:

_____

_____

_____

_____

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

- ☐ Rolls over
- ☐ Sits briefly, leans forward
- ☐ Likes to play with you
- ☐ Babbles and tries to "talk" to you
- ☐ Likes to look around
- ☐ Begins name recognition
- ☐ Smiles at people he knows
- ☐ Puts things in her mouth

Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: _____

Your Date of Birth: _____

Baby's Date of Birth: _____ Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:
- ☐ Yes, all the time
- ☒ Yes, most of the time
- ☐ No, not very often
- ☐ No, not at all

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - ☐ As much as I always could
   - ☐ Not quite so much now
   - ☐ Definitely not so much now
   - ☐ Not at all

2. I have looked forward with enjoyment to things
   - ☐ As much as I ever did
   - ☐ Rather less than I used to
   - ☐ Definitely less than I used to
   - ☐ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - ☐ Yes, most of the time
   - ☐ Yes, some of the time
   - ☐ Not very often
   - ☐ No, never

4. I have been anxious or worried for no good reason
   - ☐ No, not at all
   - ☐ Hardly ever
   - ☐ Yes, sometimes
   - ☐ Yes, very often

*5 I have felt scared or panicky for no very good reason
   - ☐ Yes, quite a lot
   - ☐ Yes, sometimes
   - ☐ No, not much
   - ☐ No, not at all

*6. Things have been getting on top of me
   - ☐ Yes, most of the time I haven't been able to cope at all
   - ☐ Yes, sometimes I haven't been coping as well as usual
   - ☐ No, most of the time I have coped quite well
   - ☐ No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - ☐ Yes, most of the time
   - ☐ Yes, sometimes
   - ☐ Not very often
   - ☐ No, not at all

*8 I have felt sad or miserable
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Not very often
   - ☐ No, not at all

*9 I have been so unhappy that I have been crying
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Only occasionally
   - ☐ No, never

*10 The thought of harming myself has occurred to me
   - ☐ Yes, quite often
   - ☐ Sometimes
   - ☐ Hardly ever
   - ☐ Never

Administered/Reviewed by _____ Date _____

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199