



Child Name: \_\_\_\_\_

## 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.

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

---



---



---

<b>Hearing</b>	Do you have concerns about how your child hears?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
<b>Vision</b>	Do you have concerns about how your child sees?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Do your child's eyes appear unusual or seem to cross, drift, or be lazy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Do your child's eyelids droop or does one eyelid tend to close?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Have your child's eyes ever been injured?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
<b>Oral Health</b>	Are cavities a problem for you or anyone else in your family?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Does your child sleep with a bottle?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Does your child continuously breastfeed through the night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
<b>Lead</b>	Does your child have a sibling or playmate who has or had lead poisoning?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Does your child live in or regularly visit a house or child care facility built before 1950?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> 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



American Academy  
of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN™

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate. Original document included as part of *Bright Futures Tool and Resource Kit*. Copyright © 2010 American Academy of Pediatrics. All Rights Reserved. The American Academy of Pediatrics does not review or endorse any modifications made to this document and in no event shall the AAP be liable for any such changes.