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.

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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? 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

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

The information contained in this questionnaire should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances. Original questionnaire included as part of the *Bright Futures Tool and Resource Kit,* 2nd Edition.

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