



Bright Futures Previsit Questionnaire 4 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	<input type="checkbox"/> Taking time for yourself <input type="checkbox"/> Having time alone with your partner <input type="checkbox"/> Spending time alone with each of your children <input type="checkbox"/> Returning to work or school <input type="checkbox"/> What is good child care
Your Changing Baby	<input type="checkbox"/> Where your baby sleeps <input type="checkbox"/> How your baby sleeps <input type="checkbox"/> How to keep your baby safe while sleeping <input type="checkbox"/> Tummy time for playtime with you <input type="checkbox"/> How to calm your baby <input type="checkbox"/> Keeping daily routines
Feeding Your Baby	<input type="checkbox"/> Breastfeeding <input type="checkbox"/> Formula feeding <input type="checkbox"/> How your baby is growing <input type="checkbox"/> Starting solid foods <input type="checkbox"/> Food allergies <input type="checkbox"/> Your child's weight
Healthy Teeth	<input type="checkbox"/> Using a pacifier <input type="checkbox"/> Teething <input type="checkbox"/> Drooling <input type="checkbox"/> Not using a bottle in bed
Safety	<input type="checkbox"/> Car safety seats <input type="checkbox"/> Preventing falls, burns, and choking <input type="checkbox"/> Not using walkers <input type="checkbox"/> Drowning and pools <input type="checkbox"/> How to check for lead in your home <input type="checkbox"/> Checking the hot water heater temperature

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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Vision	Do you have concerns about how your child sees?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Anemia	Is your child drinking anything other than breast milk or iron-fortified formula?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> 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?

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.

- | | |
|--|--|
| <input type="checkbox"/> Smiles to get your attention | <input type="checkbox"/> Likes to cuddle |
| <input type="checkbox"/> Keeps head steady when sitting up on your lap | <input type="checkbox"/> Lets you know when she likes something |
| <input type="checkbox"/> Begins to roll and reach for objects | <input type="checkbox"/> Lets you know when he does not like something |
| <input type="checkbox"/> Wants you to play | <input type="checkbox"/> Uses arms to lift chest |
| <input type="checkbox"/> Can calm down on his own | <input type="checkbox"/> Babbling |



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TO BE FILLED OUT BY PROVIDER

ACCOMPANIED BY/INFORMANT	PREFERRED LANGUAGE	DATE/TIME	Name		
DRUG ALLERGIES		CURRENT MEDICATIONS	ID NUMBER		
WEIGHT (%) <small>See growth chart.</small>	LENGTH (%)	WEIGHT FOR LENGTH (%)	HEAD CIRC (%)	TEMPERATURE	BIRTH DATE
				AGE	M F

History

Previsit Questionnaire reviewed Child has special health care needs

Concerns and questions None Addressed (see other side)

Follow-up on previous concerns None Addressed (see other side)

Interval history None Addressed (see other side)

Medication Record reviewed and updated

Social/Family History

See Initial History Questionnaire. No interval change

Family situation

Parental support—work/family balance _____

Parents working outside home: Mother Father

Child care: Yes No Type _____

Changes since last visit _____

Review of Systems

See Initial History Questionnaire and Problem List.

No interval change

Changes since last visit _____

Nutrition: Breast milk Minutes per feeding _____

Hours between feeding _____ Feedings per 24 hours _____

Problems with breastfeeding _____

Formula Ounces per feeding _____

Source of water _____ Vitamins/Fluoride _____

Elimination: NL _____

Sleep: NL _____

Behavior: NL _____

Activity (tummy time): NL _____

Development (if not reviewed in Previsit Questionnaire)

<input type="checkbox"/> PHYSICAL DEVELOPMENT	<input type="checkbox"/> COGNITIVE	<input type="checkbox"/> SOCIAL-EMOTIONAL
• Pushes chest up to elbows	• Responds to affection	• Social smile
• Good head control	• Indicates pleasure and displeasure	• Elicits social interactions
• Symmetry in movements	<input type="checkbox"/> COMMUNICATIVE	• Can calm down on own
• Begins to roll and reach for objects	• Spontaneous expressive babbling	

Physical Examination

= NL

Bright Futures Priority

SKIN (rashes, bruising)

HEAD/FONTANELLE (positional skull deformities)

EYES (red reflex/strabismus/ appears to see)

HEART

FEMORAL PULSES

MUSCULOSKELETAL (torticollis)

HIPS

NEUROLOGIC (tone, strength, symmetry)

Additional Systems

GENERAL APPEARANCE GENITALIA

LUNGS Male/Testes down

EARS/APPEARS TO HEAR Female

NOSE EXTREMITIES

MOUTH AND THROAT BACK

ABDOMEN

Abnormal findings and comments _____

Assessment

Well child

Anticipatory Guidance

Discussed and/or handout given

<input type="checkbox"/> FAMILY FUNCTIONING	<input type="checkbox"/> INFANT DEVELOPMENT	<input type="checkbox"/> SAFETY
<input type="checkbox"/> NUTRITIONAL ADEQUACY AND GROWTH	• Social development	• Car safety seat
• Breastfeeding (vitamin D, iron supplement)	• Communication skills	• Burns
• Iron-fortified formula	• Physical (tummy time)	• Hot liquids
• Solid foods	• Daily routines	• Water heaters
• When and how to add	• Sleep	• Falls
• Weight gain and growth spurts	<input type="checkbox"/> ORAL HEALTH	• Walkers
• Elimination	• Don't share utensils/pacifier	• Choking
	• Avoid bottle in bed	• Drowning
		• Lead poisoning

Plan

Immunizations (See Vaccine Administration Record.)

Laboratory/Screening results _____

Referral to _____

Follow-up/Next visit _____

See other side

Print Name	Signature
PROVIDER 1	
PROVIDER 2	



**This American Academy of Pediatrics Visit Documentation Form is consistent with
*Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, 3rd Edition.***

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.
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Bright Futures Parent Handout 4 Month Visit

Here are some suggestions from Bright Futures experts that may be of value to your family.

How Your Family Is Doing

- Take time for yourself.
- Take time together with your partner.
- Spend time alone with your other children.
- Encourage your partner to help care for your baby.
- Choose a mature, trained, and responsible babysitter or caregiver.
- You can talk with us about your child care choices.
- Hold, cuddle, talk to, and sing to your baby each day.
- Massaging your infant may help your baby go to sleep more easily.
- Get help if you and your partner are in conflict. Let us know. We can help.

FAMILY FUNCTIONING

Feeding Your Baby

- Feed only breast milk or infant-formulated formula in the first 4–6 months.

If Breastfeeding

- If you are still breastfeeding, that's great!
- Plan for pumping and storage of breast milk.

If Formula Feeding

- Make sure to prepare, heat, and store the formula safely.
- Hold your baby so you can look at each other while feeding.
- Do not prop the bottle.
- Do not give your baby a bottle in the crib.

Solid Food

- You may begin to feed your baby solid food when your baby is ready.
- Some of the signs your baby is ready for solids
 - Opens mouth for the spoon.
 - Sits with support.
 - Good head and neck control.
 - Interest in foods you eat.
- Avoid foods that cause allergy—peanuts, tree nuts, fish, and shellfish.
- Avoid feeding your baby too much by following the baby's signs of fullness

NUTRITIONAL ADEQUACY AND GROWTH

NUTRITION

- Leaning back
- Turning away
- Ask us about programs like WIC that can help get food for you if you are breastfeeding and formula for your baby if you are formula feeding.

Safety

- Use a rear-facing car safety seat in the back seat in all vehicles.
- Always wear a seat belt and never drive after using alcohol or drugs.
- Keep small objects and plastic bags away from your baby.
- Keep a hand on your baby on any high surface from which she can fall and be hurt.
- Prevent burns by setting your water heater so the temperature at the faucet is 120°F or lower.
- Do not drink hot drinks when holding your baby.
- Never leave your baby alone in bathwater, even in a bath seat or ring.
- The kitchen is the most dangerous room. Don't let your baby crawl around there; use a playpen or high chair instead.
- Do not use a baby walker.

SAFETY

Your Changing Baby

- Keep routines for feeding, nap time, and bedtime.

Crib/Playpen

- Put your baby to sleep on her back.
- In a crib that meets current safety standards, with no drop-side rail and slats no more than 2³/₈ inches apart. Find more information on the Consumer Product Safety Commission Web site at www.cpsc.gov.
- If your crib has a drop-side rail, keep it up and locked at all times. Contact the crib company to see if there is a device to keep the drop-side rail from falling down.

INFANT DEVELOPMENT

INFANT DEVELOPMENT

ORAL HEALTH

- Keep soft objects and loose bedding such as comforters, pillows, bumper pads, and toys out of the crib.
- Lower your baby's mattress.
- If using a mesh playpen, make sure the openings are less than 1/4 inch apart.

Playtime

- Learn what things your baby likes and does not like.
- Encourage active play.
 - Offer mirrors, floor gyms, and colorful toys to hold.
 - Tummy time—put your baby on his tummy when awake and you can watch.
- Promote quiet play.
 - Hold and talk with your baby.
 - Read to your baby often.

Crying

- Give your baby a pacifier or his fingers or thumb to suck when crying.

Healthy Teeth

- Go to your own dentist twice yearly. It is important to keep your teeth healthy so that you don't pass bacteria that causes tooth decay on to your baby.
- Do not share spoons or cups with your baby or use your mouth to clean the baby's pacifier.
- Use a cold teething ring if your baby has sore gums with teething.

What to Expect at Your Baby's 6 Month Visit

We will talk about

- Introducing solid food
- Getting help with your baby
- Home and car safety
- Brushing your baby's teeth
- Reading to and teaching your baby

Poison Help: 1-800-222-1222

Child safety seat inspection:
1-866-SEATCHECK; seatcheck.org



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