



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	<input type="checkbox"/> Being a good parent and partner <input type="checkbox"/> Where to go when you need help <input type="checkbox"/> Finding good child care <input type="checkbox"/> Finding and joining playgroups
Your Baby's Development	<input type="checkbox"/> How your baby learns <input type="checkbox"/> How your baby can calm down alone <input type="checkbox"/> How to keep your baby safe while sleeping <input type="checkbox"/> Bedtime routines <input type="checkbox"/> Your baby falling asleep on his own <input type="checkbox"/> Your child's weight
Feeding Your Baby	<input type="checkbox"/> Starting solid food <input type="checkbox"/> How to add new foods <input type="checkbox"/> How much food your baby should eat <input type="checkbox"/> Drinking from a cup <input type="checkbox"/> Staying on breast milk or formula <input type="checkbox"/> Food allergies
Healthy Teeth	<input type="checkbox"/> Brushing your baby's teeth <input type="checkbox"/> Need for fluoride supplements
Safety	<input type="checkbox"/> Keeping your home safe with a crawling baby <input type="checkbox"/> Car safety seats <input type="checkbox"/> Preventing burns, falls, choking, and poisoning <input type="checkbox"/> Bathing 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?	<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
Lead	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
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)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Has your child traveled (had contact with resident populations) for longer than 1 week to a country at high risk for tuberculosis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Has a family member or contact had tuberculosis or a positive tuberculin skin test?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
	Is your child infected with HIV?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
Oral Health	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

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

Adapted with permission from "Efficient Identification of Adults with Depression and Dementia," September 15, 2004, *American Family Physician*. Copyright © 2004 American Academy of Family Physicians. All Rights Reserved.

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"/> Rolls over | <input type="checkbox"/> Likes to look around |
| <input type="checkbox"/> Sits briefly, leans forward | <input type="checkbox"/> Begins name recognition |
| <input type="checkbox"/> Likes to play with you | <input type="checkbox"/> Smiles at people he knows |
| <input type="checkbox"/> Babbles and tries to "talk" to you | <input type="checkbox"/> Puts things in her mouth |



American Academy
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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 _____

Maternal depression Y N _____

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, no TV): NL _____

Development (if not reviewed in Previsit Questionnaire)

<input type="checkbox"/> PHYSICAL DEVELOPMENT	<input type="checkbox"/> COMMUNICATIVE	<input type="checkbox"/> SOCIAL-EMOTIONAL
• Sits briefly, leaning forward	• Uses a string of vowels (ah, eh, oh)	• Shows pleasure from interactions with parents or others
• Rolls over	• Beginning to recognize own name	
<input type="checkbox"/> COGNITIVE	• Begins to use oral exploration	• Enjoys vocal turn taking
• Uses visual exploration		
• Beginning to use oral exploration		

Physical Examination

= NL

Bright Futures Priority

- SKIN (rashes, bruising)
- EYES (red reflex/strabismus/ appears to see)
- HEART
- FEMORAL PULSES
- MUSCULOSKELETAL (torticollis)
- HIPS
- NEUROLOGIC (tone, strength, symmetry)

Additional Systems

- GENERAL APPEARANCE
- EARS/APPEARS TO HEAR
- NOSE
- MOUTH AND THROAT
- LUNGS
- ABDOMEN
- HEAD/FONTANELLE
- GENITALIA
- Male/Testes down
- Female
- BACK
- EXTREMITIES
- TEETH

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"/> NUTRITION AND FEEDING	• Social development	• Car safety seat
• Breastfeeding (vitamin D, iron supplement)	• Communication skills	• Poisons
• Iron-fortified formula	• Sleep	• Burns
• Solid foods	<input type="checkbox"/> ORAL HEALTH	• Falls
• Types and amounts	• Brush teeth	• Infant walkers
• Begin cup	• Avoid bottle in bed	• Drowning
• Elimination		• Choking (finger foods)
		• Kitchen safety

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 6 Month Visit

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

Feeding Your Baby

- Most babies have doubled their birth weight.
- Your baby's growth will slow down.
- If you are still breastfeeding, that's great! Continue as long as you both like.
- If you are formula feeding, use an iron-fortified formula.
- 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.

Starting New Foods

- Introduce new foods one at a time.
 - Iron-fortified cereal
- Good sources of iron include
 - Red meat
- Introduce fruits and vegetables after your baby eats iron-fortified cereal or pureed meats well.
 - Offer 1–2 tablespoons of solid food 2–3 times per day.
- Avoid feeding your baby too much by following the baby's signs of fullness.
 - Leaning back
 - Turning away
- Do not force your baby to eat or finish foods.
 - It may take 10–15 times of giving your baby a food to try before she will like it.
- Avoid foods that can cause allergies—peanuts, tree nuts, fish, and shellfish.
- To prevent choking
 - Only give your baby very soft, small bites of finger foods.
 - Keep small objects and plastic bags away from your baby.

How Your Family Is Doing

- Call on others for help.
- Encourage your partner to help care for your baby.
- Ask us about helpful resources if you are alone.
- Invite friends over or join a parent group.

FUNCTIONING

- Choose a mature, trained, and responsible babysitter or caregiver.
- You can talk with us about your child care choices.

Healthy Teeth

- Many babies begin to cut teeth.
- Use a soft cloth or toothbrush to clean each tooth with water only as it comes in.
- Ask us about the need for fluoride.
- Do not give a bottle in bed.
- Do not prop the bottle.
- Have regular times for your baby to eat. Do not let him eat all day.

ORAL HEALTH

Your Baby's Development

- Place your baby so she is sitting up and can look around.
- Talk with your baby by copying the sounds your baby makes.
- Look at and read books together.
- Play games such as peekaboo, patty-cake, and so big.
- Offer active play with mirrors, floor gyms, and colorful toys to hold.
- If your baby is fussy, give her safe toys to hold and put in her mouth and make sure she is getting regular naps and playtimes.

INFANT DEVELOPMENT

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.
- Keep soft objects and loose bedding such as comforters, pillows, bumper pads, and toys out of the crib.
- Lower your baby's mattress all the way.
- If using a mesh playpen, make sure the openings are less than ¼ inch apart.

Safety

- Use a rear-facing car safety seat in the back seat in all vehicles, even for very short trips.
- Never put your baby in the front seat of a vehicle with a passenger air bag.
- Don't leave your baby alone in the tub or high places such as changing tables, beds, or sofas.
- While in the kitchen, keep your baby in a high chair or playpen.
- Do not use a baby walker.
- Place gates on stairs.
- Close doors to rooms where your baby could be hurt, like the bathroom.
- Prevent burns by setting your water heater so the temperature at the faucet is 120°F or lower.
- Turn pot handles inward on the stove.
- Do not leave hot irons or hair care products plugged in.
- Never leave your baby alone near water or in bathwater, even in a bath seat or ring.
 - Always be close enough to touch your baby.
- Lock up poisons, medicines, and cleaning supplies; call Poison Help if your baby eats them.

SAFETY

What to Expect at Your Baby's 9 Month Visit

We will talk about

- Disciplining your baby
- Introducing new foods and establishing a routine
- Helping your baby learn
- Car seat safety
- Safety at home

Poison Help: 1-800-222-1222

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

NUTRITION AND FEEDING

FAMILY FUNCTIONING



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