



# 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?

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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

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<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:

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Have there been any major changes in your family lately?   
 Move   
 Job change   
 Separation   
 Divorce   
 Death in the family   
 Any other changes?

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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:

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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



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# TO BE FILLED OUT BY PROVIDER

ACCOMPANIED BY/INFORMANT	PREFERRED LANGUAGE	DATE/TIME
DRUG ALLERGIES	CURRENT MEDICATIONS	
WEIGHT (%) <small>See growth chart.</small>	LENGTH (%)	WEIGHT FOR LENGTH (%) HEAD CIRC (%)

Name		
ID NUMBER		
TEMPERATURE	BIRTH DATE	AGE
		M F

## History

<input type="checkbox"/> Previsit Questionnaire reviewed	<input type="checkbox"/> Child has special health care needs
Concerns and questions	<input type="checkbox"/> None <input type="checkbox"/> Addressed (see other side)
Follow-up on previous concerns	<input type="checkbox"/> None <input type="checkbox"/> Addressed (see other side)
Interval history	<input type="checkbox"/> None <input type="checkbox"/> Addressed (see other side)
<input type="checkbox"/> Medication Record reviewed and updated	

## Social/Family History

See Initial History Questionnaire.  No interval change

**Family situation**

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 \_\_\_\_\_  
 Formula Ounces per feeding \_\_\_\_\_  
 Source of water \_\_\_\_\_ Vitamins/Fluoride \_\_\_\_\_

Elimination:  NL \_\_\_\_\_

Sleep:  NL \_\_\_\_\_

Behavior:  NL \_\_\_\_\_

Activity (playtime, no TV):  NL \_\_\_\_\_

## Development

Structured developmental screen  NL Tool \_\_\_\_\_

**Developmental Surveillance** (if not reviewed in Previsit Questionnaire)

<input type="checkbox"/> PHYSICAL DEVELOPMENT	<input type="checkbox"/> COGNITIVE	<input type="checkbox"/> SOCIAL-EMOTIONAL
• Sits well	• Peekaboo	• Stranger anxiety
• Crawls	• Object permanence	• Seeks parent for comfort
• Pulls to feet with support	• Looks at books	
	<input type="checkbox"/> COMMUNICATIVE	
	• Imitates sounds	
	• Points out objects	

## Physical Examination

= NL

**Bright Futures Priority**

HEAD (positional skull deformities)

EYES (ocular mobility, eye alignment, red reflex)

HEART

FEMORAL PULSES

MUSCULOSKELETAL (torticollis)

HIPS

NEUROLOGIC (tone, strength, symmetry of movements, parachute reflex)

**Additional Systems**

<input type="checkbox"/> GENERAL APPEARANCE	<input type="checkbox"/> GENITALIA
<input type="checkbox"/> EARS/APPEARS TO HEAR	<input type="checkbox"/> Male/Testes down
<input type="checkbox"/> NOSE	<input type="checkbox"/> Female
<input type="checkbox"/> MOUTH AND THROAT	<input type="checkbox"/> BACK
<input type="checkbox"/> TEETH	<input type="checkbox"/> SKIN
<input type="checkbox"/> LUNGS	<input type="checkbox"/> EXTREMITIES
<input type="checkbox"/> ABDOMEN	

Abnormal findings and comments \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Assessment

Well child

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Anticipatory Guidance

Discussed and/or handout given

<input type="checkbox"/> FAMILY ADAPTATIONS	<input type="checkbox"/> FEEDING ROUTINE	<input type="checkbox"/> SAFETY
• Limit word "no"	• Self-feeding	• Car safety seat
• Age-appropriate discipline	• Solid foods	• Poisons
• Domestic violence	• Safe foods	• Water/Drowning
• Time for self/partner	• Using a cup	• Falls/Window guards
<input type="checkbox"/> INFANT INDEPENDENCE	• Breastfeeding (vitamin D, iron supplement)	• Burns
• Consistent routines	• Iron-fortified formula	• Guns
• Separation anxiety	• No bottle in bed	
• Learning and developing	• Brush teeth	
• No TV		

## 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.***

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# Bright Futures Parent Handout

## 9 Month Visit

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

### Your Baby and Family

- Tell your baby in a nice way what to do (“Time to eat”), rather than what not to do.
- Be consistent.
- At this age, sometimes you can change what your baby is doing by offering something else like a favorite toy.
- Do things the way you want your baby to do them—you are your baby’s role model.
- Make your home and yard safe so that you do not have to say “No!” often.
- Use “No!” only when your baby is going to get hurt or hurt others.
- Take time for yourself and with your partner.
- Keep in touch with friends and family.
- Invite friends over or join a parent group.
- If you feel alone, we can help with resources.
- Use only mature, trustworthy babysitters.
- If you feel unsafe in your home or have been hurt by someone, let us know; we can help.

FAMILY ADAPTATIONS

### Feeding Your Baby

- Be patient with your baby as he learns to eat without help.
- Being messy is normal.
- Give 3 meals and 2–3 snacks each day.
- Vary the thickness and lumpiness of your baby’s food.
- Start giving more table foods.
- Give only healthful foods.
- Do not give your baby soft drinks, tea, coffee, and flavored drinks.
- Avoid forcing the baby to eat.
- Babies may say no to a food 10–12 times before they will try it.
- Help your baby to use a cup.

FEEDING ROUTINE

FEEDING ROUTINE

- Continue to breastfeed or bottle-feed until 1 year; do not change to cow’s milk.
- Avoid feeding foods that are likely to cause allergy—peanut butter, tree nuts, soy and wheat foods, cow’s milk, eggs, fish, and shellfish.

### Your Changing and Developing Baby

- Keep daily routines for your baby.
- Make the hour before bedtime loving and calm.
- Check on, but do not pick up, the baby if she wakes at night.
- Watch over your baby as she explores inside and outside the home.
- Crying when you leave is normal; stay calm.
- Give the baby balls, toys that roll, blocks, and containers to play with.
- Avoid the use of TV, videos, and computers.
- Show and tell your baby in simple words what you want her to do.
- Avoid scaring or yelling at your baby.
- Help your baby when she needs it.
- Talk, sing, and read daily.

INFANT INDEPENDENCE

### Safety

- Use a rear-facing car safety seat in the back seat in all vehicles.
- Have your child’s car safety seat rear-facing until your baby is 2 years of age or until she reaches the highest weight or height allowed by the car safety seat’s manufacturer.
- Never put your baby in the front seat of a vehicle with a passenger air bag.
- Always wear your own seat belt and do not drive after using alcohol or drugs.
- Empty buckets, pools, and tubs right after you use them.

SAFETY

- Place gates on stairs; do not use a baby walker.
- Do not leave heavy or hot things on tablecloths that your baby could pull over.
- Put barriers around space heaters, and keep electrical cords out of your baby’s reach.
- Never leave your baby alone in or near water, even in a bath seat or ring. Be within arm’s reach at all times.
- Keep poisons, medications, and cleaning supplies locked up and out of your baby’s sight and reach.
- Call Poison Help (1-800-222-1222) if you are worried your child has eaten something harmful.
- Install openable window guards on second-story and higher windows and keep furniture away from windows.
- Never have a gun in the home. If you must have a gun, store it unloaded and locked with the ammunition locked separately from the gun.
- Keep your baby in a high chair or playpen when in the kitchen.

SAFETY

### What to Expect at Your Child’s 12 Month Visit

#### We will talk about

- Setting rules and limits for your child
- Creating a calming bedtime routine
- Feeding your child
- Supervising your child
- Caring for your child’s teeth

Poison Help: 1-800-222-1222

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



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