**Bright Futures Previsit Questionnaire**

**2 to 5 Day (First Week) 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.

### How You Are Feeling
- [ ] Your health
- [ ] Feeling sad
- [ ] Family stress
- [ ] Unwanted advice
- [ ] Starting a daily routine

### Getting Used to Your Baby
- [ ] How you are doing with your baby
- [ ] Calming your baby
- [ ] Crib safety
- [ ] Where your baby sleeps
- [ ] How your baby sleeps
- [ ] Placing baby on back to sleep

### Feeding Your Baby
- [ ] Gaining weight
- [ ] How your baby shows if he/she is hungry or full
- [ ] Drinking enough

- [ ] Jaundice (skin is yellow)
- [ ] Burping
- [ ] Breastfeeding
- [ ] Formula

### Safety
- [ ] Car safety seat
- [ ] Cigarette smoke
- [ ] Water heater temperature

### Baby Care
- [ ] When to call the doctor's office
- [ ] Taking your baby's temperature
- [ ] Not getting sick
- [ ] Hand washing
- [ ] Emergency situations
- [ ] Leaving the house
- [ ] Skin care
- [ ] Sunburns

**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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**Vision**

Do you have concerns about how your child sees? [ ] Yes [ ] No [ ] Unsure

Does your child have any special health care needs? [ ] Yes, describe:

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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? Describe:

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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

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Does your child live with anyone who uses tobacco or spend time in any place where people smoke? [ ] No [ ] Yes

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**Your Growing and Developing Baby**

Do you have specific concerns about how your baby is growing, learning, or acting? [ ] No [ ] Yes, describe:

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Check off each of the tasks that your baby is able to do.

- [ ] Eats well
- [ ] Looks and acts like you
- [ ] Follows your face
- [ ] Can suck, swallow, and breathe easily

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*American Academy of Pediatrics*

**DEDICATED TO THE HEALTH OF ALL CHILDREN**

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