Bright Futures Parent Supplemental 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 circle Yes or No for each question. Thank you.

How Your Family Is Doing: Family Functioning

Are you and your partner getting along?		Yes	No
Have you and your partner been getting out alone?		Yes	No
Are you able to care for your baby?		Yes	No
Have you returned to work or school?		No	Yes
Are you able to spend time alone with your older children?	N/A	Yes	No
Do other family members and friends help you take care of your baby?		Yes	No

Your Changing Baby: Infant Development

Do you hold, cuddle, talk with, and play with your baby?	Yes	No
Does your baby have a regular daily schedule for feeding, napping, and playing?	Yes	No
Can your baby sleep for 5–6 hours at night?	Yes	No
Do you have a bedtime routine for your baby?	Yes	No
Does your baby sleep on his back?	Yes	No
Does your baby sleep in a crib?	Yes	No
Have you talked with your child care provider about your baby always sleeping on her back?	Yes	No
Does your baby spend time with you on his tummy when awake?	Yes	No
Are you able to calm your baby?	Yes	No
How many hours per day does your baby watch TV?	_____ hours	

Feeding Your Baby: Nutritional Adequacy and Growth

What are you feeding your baby?	Breast Milk	Formula	Both
If your baby is breastfed, is your baby taking vitamin D supplements?	N/A	Yes	No
If your baby is formula-fed, is your baby on iron-fortified formula?	N/A	Yes	No
Are you thinking about when you should start giving your baby solid foods?		No	Yes
Do you know what the signs are that your baby is ready to eat solid foods?		Yes	No

Healthy Teeth: Oral Health

Do you regularly see a dentist and brush and floss your teeth?	Yes	No
Do you let your baby have a bottle in the crib?	No	Yes
Is your baby showing signs of teething such as drooling, having a fever, or being fussy?	No	Yes

Safety

Do you always use a car safety seat?	Yes	No
Is your baby's car safety seat always rear-facing in the back seat of the car?	Yes	No
Are you having any problems with your car safety seat?	No	Yes
Do you always stay in arm's reach of your baby when he is in the bath, even if you use a bath seat ring?	Yes	No
Do you always keep one hand on your baby when changing her diaper?	Yes	No
Is your hot water temperature set at or below 120°F at the faucet?	Yes	No
Do you ever drink or carry hot liquids when holding your baby?	No	Yes
Does anyone smoke around your baby?	No	Yes
If you smoke, would you like information on how to stop?	Yes	No

Bright Futures Medical Screening Questionnaire
4 Month Visit

Please answer the following questions about your child's health by circling Y, N, or Unsure.

Do you have concerns about how your child hears?	Y	N	Unsure
Do you have concerns about how your child sees?	Y	N	Unsure
Is your child drinking anything other than breast milk or iron-fortified formula?	Y	N	Unsure

Bright Futures
prevention and health promotion for infants, children, adolescents, and their families™

American Academy of Pediatrics
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