

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 an	y concerns, question	s, or problems that you would like to discuss today?					
We are interest	ad in anaarinaa	suppliers. Discooperate off the boung for the tonics you would like to discoop the					
we are interest	eu iii answering your	questions. Please check off the boxes for the topics you would like to discuss the most today.					
Your Baby and Family Your Changing and		☐ Having time alone for yourself ☐ Having time alone with your partner ☐ Feeling safe in your home ☐ Your family's ideas about how your baby should act ☐ Your baby's behavior					
		☐ How your baby is learning ☐ Games and toys that help your baby learn ☐ Your baby's nighttime routine					
Developing Baby		☐ Waking up at night ☐ Crying with new people					
Developing Baby		□ Baby feeding himself □ Adding solid and table food □ Increasing the thickness of foods □ Using a cup					
Feeding Your Baby Safety		☐ Continuing breastfeeding and formula-feeding ☐ Your baby's weight					
		☐ Keeping your home safe with an active baby ☐ Car safety seats ☐ Preventing burns, falls, and poisoning					
		☐ Gun safety ☐ Water and bathtub safety					
		Questions About Your Baby					
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Have any of you	ir dady's relatives de	veloped new medical problems since your last visit? If yes, please describe:	☐ Yes	☐ No	■ Unsure		
Hearing	Do you have conce	erns about how your child hears?	☐ Yes	□ No	☐ Unsure		
Vision	Do you have concerns about how your child sees?			□ No	□ Unsure		
	Do your child's eyes appear unusual or seem to cross, drift, or be lazy?			□ No	Unsure		
	Do your child's eyelids droop or does one eyelid tend to close?			□ No	☐ Unsure		
	Have your child's eyes ever been injured?			□ No	□ Unsure		
Oral Health	Are cavities a problem for you or anyone else in your family?			□ No	☐ Unsure		
	Does your child sleep with a bottle?			□ No	☐ Unsure		
	Does your child continuously breastfeed through the night?			□ No	☐ Unsure		
	-	ve a sibling or playmate who has or had lead poisoning?	☐ Yes	□ No	☐ Unsure		
Lead	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?			□ No	☐ Unsure		
	Does your child live	e in or regularly visit a house or child care facility built before 1950?	☐ Yes	□ No	☐ Unsure		
Does your child	have any special he	alth care needs?					
-							
Have there been	n any major changes	in your family lately? $\ \square$ Move $\ \square$ Job change $\ \square$ Separation $\ \square$ Divorce $\ \square$ Dea	th in the fam	ily 🖵 An	y other change		
Does your child	live with anyone wh	o uses tobacco or spend time in any place where people smoke? 🗖 No 💢 Ye	S				

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.							
☐ 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							



American Academy of Pediatrics



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