# 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** | ☐ Being a good parent and partner ☐ Where to go when you need help ☐ Finding good child care ☐ Finding and joining playgroups |
| **Your Baby's Development** | ☐ How your baby learns ☐ How your baby can calm down alone ☐ How to keep your baby safe while sleeping ☐ Bedtime routines ☐ Your baby falling asleep on his own ☐ Your child's weight |
| **Feeding Your Baby** | ☐ Starting solid food ☐ How to add new foods ☐ How much food your baby should eat ☐ Drinking from a cup ☐ Staying on breast milk or formula ☐ Food allergies |
| **Healthy Teeth** | ☐ Brushing your baby's teeth ☐ Need for fluoride supplements |
| **Safety** | ☐ Keeping your home safe with a crawling baby ☐ Car safety seats ☐ Preventing burns, falls, choking, and poisoning ☐ Bathtub 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? | ☐ Yes | ☐ No | ☐ Unsure |
| **Vision** | Do you have concerns about how your child sees? | ☐ Yes | ☐ No | ☐ Unsure |
| **Lead** | Does your child have a sibling or playmate who has or had lead poisoning? | ☐ Yes | ☐ No | ☐ 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? | ☐ Yes | ☐ No | ☐ Unsure |
| | Does your child live in or regularly visit a house or child care facility built before 1950? | ☐ Yes | ☐ No | ☐ 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)? | ☐ Yes | ☐ No | ☐ Unsure |
| | Has your child traveled (had contact with resident populations) for longer than 1 week to a country at high risk for tuberculosis? | ☐ Yes | ☐ No | ☐ Unsure |
| | Has a family member or contact had tuberculosis or a positive tuberculin skin test? | ☐ Yes | ☐ No | ☐ Unsure |
| | Is your child infected with HIV? | ☐ Yes | ☐ No | ☐ Unsure |
| **Oral Health** | Are cavities a problem for you or anyone else in your family? | ☐ Yes | ☐ No | ☐ Unsure |
| | Does your child sleep with a bottle? | ☐ Yes | ☐ No | ☐ Unsure |
| | Does your child continuously breastfeed through the night? | ☐ Yes | ☐ No | ☐ 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



**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.**

- ☐ Rolls over
- ☐ Sits briefly, leans forward
- ☐ Likes to play with you
- ☐ Babbles and tries to "talk" to you
- ☐ Likes to look around
- ☐ Begins name recognition
- ☐ Smiles at people he knows
- ☐ Puts things in her mouth

| ACCOMPANIED BY/INFORMANT | PREFERRED LANGUAGE | DATE/TIME | Name |
|---|---|---|---|
| | | | |

| DRUG ALLERGIES | CURRENT MEDICATIONS | ID NUMBER |
|---|---|---|
| | | |

| WEIGHT (%) | LENGTH (%) | WEIGHT FOR LENGTH (%) | HEAD CIRC (%) | TEMPERATURE | BIRTH DATE | AGE |
|---|---|---|---|---|---|---|
| See growth chart. | | | | | | ☐ 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)

☐ PHYSICAL DEVELOPMENT
- Sits briefly, leaning forward
- Rolls over

☐ COGNITIVE
- Uses visual exploration
- Beginning to use oral exploration

☐ COMMUNICATIVE
- Uses a string of vowels (ah, eh, oh)
- Beginning to recognize own name
- Enjoys vocal turn taking

☐ SOCIAL-EMOTIONAL
- Shows pleasure from interactions with parents or others

## 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

☐ FAMILY FUNCTIONING

☐ NUTRITION AND FEEDING
- Breastfeeding (vitamin D, iron supplement)
- Iron-fortified formula
- Solid foods
  - Types and amounts
  - Begin cup
- Elimination

☐ INFANT DEVELOPMENT
- Social development
- Communication skills
- Sleep

☐ ORAL HEALTH
- Brush teeth
- Avoid bottle in bed

☐ SAFETY
- Car safety seat
- Poisons
- Burns
  - Hot water
- Falls
- Infant walkers
- Drowning
- 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 | |

American Academy of Pediatrics
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**This American Academy of Pediatrics Visit Documentation Form is consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents,* 3rd Edition.**

# Bright Futures Parent Handout
# 6 Month Visit

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

NUTRITION AND FEEDING

## 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.
- The only foods to be avoided are raw honey or chunks of food that could cause choking. Newer data suggest that the early introduction of all foods may actually prevent individual food allergies.
- To prevent choking
  - Only give your baby very soft, small bites of finger foods.
  - Keep small objects and plastic bags away from your baby.

FAMILY FUNCTIONING

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

ORAL HEALTH

## Healthy Teeth

- Many babies begin to cut teeth.
- Clean gums and teeth (as soon as you see the first tooth) 2 times per day with a soft cloth or soft toothbrush with a small smear of fluoride toothpaste (the size of a grain of rice).
- 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.

INFANT DEVELOPMENT

## 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.

### 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 2 3/8 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

## 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.

## 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

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

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