406-M Northside Drive Valdosta, GA 31602 Ph. 229 • 241 • 0059 Fax 229 • 241 • 2088

PATIENT				
Last Name	First Name	MI	Date of Birth	
PARENT/GUARDIAN				
Last Name	Firs	st Name	MI	

Patient Eligibility Screening Record

Vaccines for Children Program

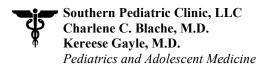
Provider: Southern Pediatric Clinic

A record must be kept in the healthcare provider's office that reflects the status of all children 18 years of age or younger, who receive immunizations with vaccines supplied by state programs. The record my be completed by the parent, guardian or individual of record, or by the healthcare provider. The same record may be used for all subsequent visits s long as the child's eligibility status has not changed. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccine(s).

NOTE: IF you do not have health insurance or if your insurance carrier does not cover vaccines, you can receive a vaccine provided by the Vaccines for Children Program. A fee of \$21.93 per shot will be charged at the time of service. Only children 18 years and younger are eligible for this program.

Check only ONE (1) box. My child		
(A) is enrolled in Medicaid (Peach State , WellCare, AmeriGroup, CareSource or SSI Medicaid).		OR
(B) is American Indian or Alaskan Native.		OR
(C) does not have health insurance.		OR
(D) has health insurance that does not pay for vaccines.		OR
(E) is enrolled in PeachCare (PeachCare will be listed as Managed Care Provider).	\bigcirc	OR
(F) has health insurance that pays for vaccines.	\bigcirc	

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						Date	
	Child's Name			Date of	of Birth		
PHQ-2							
			4. 3	N	G .	More	Nearly

Over the last two weeks, how often have you been bothered by any of the following problems? 1. Little interest or pleasure in doing things. 2. Feeling down, depressed, or hopeless.

STOP HERE if you ANSWERED "not at all" to the above 2 questions!

PHQ-9

Over the last two weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
3. Trouble falling or staying asleep, or sleeping too much.				
4. Feeling tired or having little energy				
5. Poor appetite or overeating.				
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down.				
7. Trouble concentrating on things, such as reading the newspaper or watching television.				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual				
9. Thoughts that you would be better off dead or of hurting yourself in some way				

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all Somewhat difficult Very	difficult Extrememly difficult
--	--------------------------------

PATIENT NAME:		DATE:	
	Please print.		

American Academy of Pediatrics

BRIGHT FUTURES PREVISIT QUESTIONNAIRE 1 MONTH VISIT and Younger



To provide you and your baby with the best possible health care, we would like to know how things are going. Please answer all the questions. **Maternal Depression screening is also part of this visit.** Thank you.

WHAT W	VOULD YOU LIKE TO TALK ABOUT	TODAY?
Do you have any concerns, questions, or prob	olems that you would like to discuss today? O N	o O Yes, describe:
TEL	L US ABOUT YOUR BABY AND FAM	MILY.
What excites or delights you most about your	baby?	
Does your baby have special health care need	ds? O No O Yes, describe:	
Have there been major changes lately in your	baby's or family's life? O No O Yes , describe:	
Have any of your baby's relatives developed ne please describe:	ew medical problems since your last visit? O No	○ Yes ○ Unsure If yes or unsure,
Does your baby live with anyone who smokes	or spend time in places where people smoke or	use e-cigarettes? O No O Yes O Unsure
YOU	JR GROWING AND DEVELOPING B	ABY
Do you have specific concerns about your bab	by's development, learning, or behavior? O No	O Yes, describe:
Check off each of the tasks that your baby	is able to do.	
 □ Look at you. □ Follow you with her eyes. □ Comfort himself by doing things such as bringing his hands to his mouth. □ Start to get fussy when she is bored. □ Calm when he is picked up or spoken to. □ Look briefly at objects. 	 ☐ Make short sounds such as "ooh" and "ah." ☐ Become alert when she hears unexpected sounds. ☐ Become quiet or turn when he hears your voice. ☐ Show signs she is sensitive to her surroundings (such as crying or startling) or need extra support to handle daily activities. 	 ☐ Use different cries for hunger and tiredness. ☐ Move both arms and legs together. ☐ Hold his chin up when he is on his stomach. ☐ Open her fingers a little when at rest.

PATIENT NAME:		DATE:	
	Please print.	_	

1 MONTH VISIT

	RISK ASSESSMENT			
_	Was your baby or any household member born in, or has he or she traveled to, a country where tuberculosis is common (this includes countries in Africa, Asia, Latin America, and Eastern Europe)?	O No	O Yes	O Unsure
Tuberculosis	Has your baby had close contact with a person who has tuberculosis disease or who has had a positive tuberculosis test result?	O No	O Yes	O Unsure
	Is your baby infected with HIV?	O No	O Yes	O Unsure
Vision	Do you have concerns about how your baby sees?	O No	O Yes	O Unsure

ANTICIPATORY GUIDANCE

How are things going for you, your baby, and your family?

YOUR FAMILY'S HEALTH AND WELL-BEING

spermanent housing a worry for you? O you have the things you need to take care of your baby, such as a crib, a car safety seat, and diapers? O yes O you book over home have enough heat, hot water, and electricity? O yes O No you have health insurance for yourself? Within the past 12 months, were you ever worried whether your food would run out before you got money to buy more? O you on home have nealth insurance for yourself? Within the past 12 months, were you ever worried whether your food would run out before you got money to buy more? O you on need help in finding community support services, such as WIC or food stamps? O No O ye lave you had any problems with mold or dampness in your home? O you use pesticides inside or outside your home? O you use pesticides inside or outside your home? O you always feel safe in your home? O you always feel safe in your home? O you always feel safe in your home? O you on on the say? Waternal Alcohol and Substance Use O you or other family members use marijuana, cocaine, pain pills, narcotics, or other controlled substances? O you or other family members use marijuana, cocaine, pain pills, narcotics, or other controlled substances? O yes O No O y	TOOR PAINILL S REALTH AND WELL-BEING			
Do you have the things you need to take care of your baby, such as a crib, a car safety seat, and diapers? O Yes O No Does your home have enough heat, hot water, and electricity? O Yes O you have health insurance for yourself? O Yes O No Do you have health insurance for yourself? O Yes O No Do you have health insurance for yourself? O Yes O No Do you have health insurance for yourself? O No O Yes O No Do you have health insurance for yourself? O No O Yes	Living Situation and Food Security			
Does your home have enough heat, hot water, and electricity? O you have health insurance for yourself? O you have health insurance for yourself? O you have health insurance for yourself? O Yes O you have health insurance for yourself? O No O Yes Within the past 12 months, were you ever worried whether your food would run out before you got money to buy more? O No O Ye O No O Yes O No O Yes Oo you need help in finding community support services, such as WIC or food stamps? O NO O Ye I our home has a basement, has it been checked for radon? O NO O Yes O you use pesticides inside or outside your home? O NO O Yes O you always feel safe in your home? O Yes O you always feel safe in your home? O Yes	Is permanent housing a worry for you?		O No	O Yes
Do you have health insurance for yourself? O you have health insurance for yourself? Within the past 12 months, were you ever worried whether your food would run out before you got money to buy more? O No O ye Within the past 12 months, did the food you bought not last, and you did not have money to get more? O No O ye Do you need help in finding community support services, such as WIC or food stamps? O NO O ye Takey you had any problems with mold or dampness in your home? If your home has a basement, has it been checked for radon? O you use pesticides inside or outside your home? O you always feel safe in your home? O you out partner, or another significant person in your life, ever hit, kicked, or shoved you, or physically hurt you or the baby? Waternal Alcohol and Substance Use Does anyone in your household drink beer, wine, or liquor? O you or other family members use marijuana, cocaine, pain pills, narcotics, or other controlled substances? O you or other family members use marijuana, cocaine, pain pills, narcotics, or other controlled substances? O you feel comfortable returning to work or school after the baby's birth? I dave you made arrangements for child care? O yes O No OYES O yes O No OYES O yes O No CARING FOR YOUR BABY Seyour baby sleeping well? O yes o No CARING FOR YOUR BABY Seyour baby sleeping well? O yes O No O y	Do you have the things you need to take care of your baby, such as a crib, a car safety seat, and diapers?		O Yes	O No
Within the past 12 months, were you ever worried whether your food would run out before you got money to buy more? O No O Yee Within the past 12 months, did the food you bought not last, and you did not have money to get more? O No O Yee Do you need help in finding community support services, such as WIC or food stamps? O NO O Yee Jave you had any problems with mold or dampness in your home? (your home has a basement, has it been checked for radon? O NO O Yee Jo you use pesticides inside or outside your home? O you always feel safe in your home? O you always feel safe in your home? O you always feel safe in your home? O you prattner, or another significant person in your life, ever hit, kicked, or shoved you, or physically hurt you or the baby? Waternal Alcohol and Substance Use O you or other family members use marijuana, cocaine, pain pills, narcotics, or other controlled substances? O you go you feel comfortable returning to work or school after the baby's birth? O you feel comfortable returning to work or school after the baby's birth? O you feel comfortable returning to work or school after the baby and help around the house? O Yes O you so you partner or do other family members help care for the baby and help around the house? I O Yes O Yes O No	Does your home have enough heat, hot water, and electricity?		O Yes	O No
Within the past 12 months, did the food you bought not last, and you did not have money to get more? O No O Yes Oo you need help in finding community support services, such as WIC or food stamps? O No O Yes Have you had any problems with mold or dampness in your home? O No O Yes Oo you use pesticides inside or outside your home? O No O Yes Oo you use pesticides inside or outside your home? O Yes Oo you always feel safe in your home? O Yes Oo you always feel safe in your home? O Yes Oo you always feel safe in your home? O Yes Oo you always feel safe in your home? O No O Yes Oo you always feel safe in your home? O Yes Oo you or the baby? Waternal Alcohol and Substance Use Oo you or other family members use marijuana, cocaine, pain pills, narcotics, or other controlled substances? O Yes Oo you or other family members use marijuana, cocaine, pain pills, narcotics, or other controlled substances? O Yes Oo you feel comfortable returning to work or school after the baby's birth? O you feel comfortable returning to work or school after the baby's birth? O you feel comfortable returning to work or school after the baby's birth? O you feel comfortable returning to work or school after the baby's birth? O you feel comfortable returning to work or school after the baby's birth? O you feel comfortable returning to work or school after the baby and help around the house? O Yes O No O Yes O No CARING FOR YOUR BABY S your baby sleeping well? O Yes O No O Yes O Yes O No O Yes O No O Yes	Do you have health insurance for yourself?		O Yes	O No
Do you need help in finding community support services, such as WIC or food stamps? O No O Yes Have you had any problems with mold or dampness in your home? f your home has a basement, has it been checked for radon? O NA O Yes O NO O you use pesticides inside or outside your home? O you use pesticides inside or outside your home? O you always feel safe in your home? O you on another significant person in your life, ever hit, kicked, or shoved you, or physically hurt you or the baby? Maternal Alcohol and Substance Use O you or other family members use marijuana, cocaine, pain pills, narcotics, or other controlled substances? O you or other family members use marijuana, cocaine, pain pills, narcotics, or other controlled substances? O yes O No O Yes MOTHER'S HEALTH AND FAMILY RELATIONSHIPS Have you had a post-birth checkup? O yes your partner or do other family members help care for the baby and help around the house? f you have older children, are they getting along with the baby? S your baby sleeping well? O Yes O No O CARING FOR YOUR BABY S your baby use a pacifier? O Yes O No	Within the past 12 months, were you ever worried whether your food would run out before you got money to buy	more?	O No	O Yes
Have you had any problems with mold or dampness in your home? f your home has a basement, has it been checked for radon? O NA O Yes O you use pesticides inside or outside your home? O you use pesticides inside or outside your home? O you always feel safe in your home? O you or the baby? O you or the baby? O NO O Yes O you or other family members use marijuana, cocaine, pain pills, narcotics, or other controlled substances? O you or other family members use marijuana, cocaine, pain pills, narcotics, or other controlled substances? O you for you for other family members use marijuana, cocaine, pain pills, narcotics, or other controlled substances? O you feel comfortable returning to work or school after the baby's birth? O you feel comfortable returning to work or school after the baby's birth? O you feel comfortable returning to work or school after the baby's birth? Have you made arrangements for child care? O Yes O No MOTHER'S HEALTH AND FAMILY RELATIONSHIPS Have you had a post-birth checkup? O yes O No CARING FOR YOUR BABY S your baby sleeping well? O Yes O No CARING FOR YOUR BABY Can you tell what your baby wants by how she cries? O Yes O No O Yes O No O Yes O Yes O No O Yes O No O Yes O No O Yes O No O Yes O No O Yes O Yes O No O Yes O N	Within the past 12 months, did the food you bought not last, and you did not have money to get more?		O No	O Yes
region from the has a basement, has it been checked for radon? O NA O Yes O No O Yes O Ye	Do you need help in finding community support services, such as WIC or food stamps?		O No	O Yes
Do you use pesticides inside or outside your home? O No O Yes ntimate Partner Violence Do you always feel safe in your home? O you always feel safe in your home? O No O Yes o No O Yes waternal Alcohol and Substance Use Does anyone in your household drink beer, wine, or liquor? O you or other family members use marijuana, cocaine, pain pills, narcotics, or other controlled substances? O Yes O No O Ye	Have you had any problems with mold or dampness in your home?		O No	O Yes
Intimate Partner Violence Do you always feel safe in your home? Do you partner, or another significant person in your life, ever hit, kicked, or shoved you, or physically hurt you or the baby? Waternal Alcohol and Substance Use Does anyone in your household drink beer, wine, or liquor? Do you or other family members use marijuana, cocaine, pain pills, narcotics, or other controlled substances? Do you feel comfortable returning to work or school after the baby's birth? Do you feel comfortable returning to work or school after the baby's birth? Do you feel comfortable returning to work or school after the baby's birth? Do you feel comfortable returning to work or school after the baby's birth? Do you feel comfortable returning to work or school after the baby's birth? Do you feel comfortable returning to work or school after the baby's birth? Do you feel comfortable returning to work or school after the baby's birth? Do you feel comfortable returning to work or school after the baby's birth? Do you feel comfortable returning to work or school after the baby's birth? Do you feel comfortable returning to work or school after the baby's birth? Do you feel comfortable returning to work or school after the baby's birth? Do you feel comfortable returning to work or school after the baby's birth? Do you feel comfortable returning to work or school after the baby's birth? Do you feel comfortable returning to work or school after the baby's birth? Do you feel comfortable returning to work or school after the baby's birth? Do you be dead arrangements for child care? Do you be dead ar	If your home has a basement, has it been checked for radon?	O NA	O Yes	O No
Do you always feel safe in your home? It as your partner, or another significant person in your life, ever hit, kicked, or shoved you, or physically hurt you or the baby? Maternal Alcohol and Substance Use Does anyone in your household drink beer, wine, or liquor? Do you or other family members use marijuana, cocaine, pain pills, narcotics, or other controlled substances? Does you feel comfortable returning to work or school after the baby's birth? Do you feel comfortable returning to work or school after the baby's birth? Does you made arrangements for child care? Does you partner or do other family members help care for the baby and help around the house? Ones your partner or do other family members help care for the baby and help around the house? Ones your partner or do other family members help care for the baby and help around the house? Ones your baby sleeping well? Ones your baby use a pacifier? Ones your baby use a pacifier? Ones your baby wants by how she cries? Ones you able to calm your baby? Ones you able to calm your baby? Ones you baby is not be baby? Ones you baby is not be baby? Ones your baby is not be baby? Ones your baby wants by how she cries? Ones you able to calm your baby? Ones you baby is not be baby; Ones your baby is not be calm your baby? Ones you baby is not be baby; Ones you be a pacifier? Ones you baby is not be baby; Ones your baby is not be room?	Do you use pesticides inside or outside your home?		O No	O Yes
Has your partner, or another significant person in your life, ever hit, kicked, or shoved you, or physically hurt you or the baby? Maternal Alcohol and Substance Use Does anyone in your household drink beer, wine, or liquor? Do you or other family members use marijuana, cocaine, pain pills, narcotics, or other controlled substances? Do you feel comfortable returning to work or school after the baby's birth? Do you feel comfortable returning to work or school after the baby's birth? Do you made arrangements for child care? MOTHER'S HEALTH AND FAMILY RELATIONSHIPS Have you had a post-birth checkup? Does your partner or do other family members help care for the baby and help around the house? If you have older children, are they getting along with the baby? CARING FOR YOUR BABY So your baby sleeping well? Does your baby use a pacifier? Can you tell what your baby wants by how she cries? Are you able to calm your baby? So No O Yes O No O	Intimate Partner Violence			
Maternal Alcohol and Substance Use Does anyone in your household drink beer, wine, or liquor? Do you or other family members use marijuana, cocaine, pain pills, narcotics, or other controlled substances? Do you feel comfortable returning to work or school after the baby's birth? Do you feel comfortable returning to work or school after the baby's birth? Do you feel comfortable returning to work or school after the baby's birth? Do you feel comfortable returning to work or school after the baby's birth? Does you made arrangements for child care? MOTHER'S HEALTH AND FAMILY RELATIONSHIPS Does your partner or do other family members help care for the baby and help around the house? Ones your partner or do other family members help care for the baby and help around the house? Ones your baby sleeping well? Ones your baby sleeping well? Ones your baby use a pacifier? Ones your baby use a pacifier? Ones you tell what your baby wants by how she cries? Ones you able to calm your baby? Ones at TV, computer, tablet, or smartphone on in the background while your baby is in the room? Ones would be compared to the packground while your baby is in the room?	Do you always feel safe in your home?		O Yes	O No
Coes anyone in your household drink beer, wine, or liquor? Oo you or other family members use marijuana, cocaine, pain pills, narcotics, or other controlled substances? Family Support Oo you feel comfortable returning to work or school after the baby's birth? On you feel comfortable returning to work or school after the baby's birth? On you made arrangements for child care? On yes on Note that the post-birth checkup? On you had a post-birth checkup? On you partner or do other family members help care for the baby and help around the house? On yes on Note that you have older children, are they getting along with the baby? CARING FOR YOUR BABY So your baby sleeping well? On yes on Note that your baby wants by how she cries? On yes on Note you tell what your baby wants by how she cries? On yes on Note yes on Note yes on Note your baby to calm your baby? On you have older children, are they getting along with the baby? On yes on Note your baby use a pacifier? On yes on Note yes on Note yes your baby use a pacifier? On you tell what your baby wants by how she cries? On you have you have older children, are they getting along with the baby? On you have older children, are they getting along with the baby? On you have older children, are they getting along with the baby? On you have older children, are they getting along with the baby? On you have older children, are they getting along with the baby? On you have older children, are they getting along with the baby? On you you baby sleeping well? On you you baby sleeping w	Has your partner, or another significant person in your life, ever hit, kicked, or shoved you, or physically hurt you or the baby?		O No	O Yes
Do you or other family members use marijuana, cocaine, pain pills, narcotics, or other controlled substances? O you feel comfortable returning to work or school after the baby's birth? O you feel comfortable returning to work or school after the baby's birth? O Yes O Note O Yes O Y	Maternal Alcohol and Substance Use		<u> </u>	
Family Support Oo you feel comfortable returning to work or school after the baby's birth? Have you made arrangements for child care? O Yes O Note MOTHER'S HEALTH AND FAMILY RELATIONSHIPS Have you had a post-birth checkup? O Yes O Note Obes your partner or do other family members help care for the baby and help around the house? If you have older children, are they getting along with the baby? O NA O Yes O Note CARING FOR YOUR BABY S your baby sleeping well? O Yes O Note Can you tell what your baby wants by how she cries? Are you able to calm your baby? O No O Yes O Note O Yes O Yes O Note O Yes O	Does anyone in your household drink beer, wine, or liquor?		O No	O Yes
Or you feel comfortable returning to work or school after the baby's birth? Have you made arrangements for child care? MOTHER'S HEALTH AND FAMILY RELATIONSHIPS Have you had a post-birth checkup? Or Yes Or Not Does your partner or do other family members help care for the baby and help around the house? f you have older children, are they getting along with the baby? CARING FOR YOUR BABY S your baby sleeping well? Or Yes Or Not Does your baby use a pacifier? Or Yes Or Not Does your baby wants by how she cries? Or Yes Or Not Does your baby wants by how she cries? Or Yes Or Not Does your baby wants by how she cries? Or Yes Or Not Does your baby wants by how she cries? Or Yes Or Not Does your baby wants by how she cries? Or Yes Or Not Does your baby wants by how she cries? Or Yes Or Not Does your baby wants by how she cries? Or Yes Or Not Does your baby wants by how she cries? Or Yes Or Not Does your baby wants by how she cries?	Do you or other family members use marijuana, cocaine, pain pills, narcotics, or other controlled substances?		O No	O Yes
Have you made arrangements for child care? MOTHER'S HEALTH AND FAMILY RELATIONSHIPS Have you had a post-birth checkup? Oyes Ond CARING FOR YOUR BABY S your baby sleeping well? Oyes Ond Can you tell what your baby wants by how she cries? Oyes Ond Oyes Oyes Oyes Ond Oyes Oyes Oyes Ond Oyes Oyes Oyes Oyes Oyes Oyes	Family Support		<u> </u>	
MOTHER'S HEALTH AND FAMILY RELATIONSHIPS Have you had a post-birth checkup? Opes your partner or do other family members help care for the baby and help around the house? If you have older children, are they getting along with the baby? CARING FOR YOUR BABY Is your baby sleeping well? Opes your baby use a pacifier? Opes your baby use a pacifier? Opes your baby wants by how she cries? Are you able to calm your baby? In your baby is in the room? Opes Opes Opes Opes Opes Opes Opes Opes	Do you feel comfortable returning to work or school after the baby's birth?		O Yes	O No
Are you had a post-birth checkup? O Yes O Note of your partner or do other family members help care for the baby and help around the house? O Yes O Note of you have older children, are they getting along with the baby? CARING FOR YOUR BABY S your baby sleeping well? O Yes O Note of your baby use a pacifier? O Yes O Note of your baby use a pacifier? O Yes O Note of your baby wants by how she cries? Are you able to calm your baby? S a TV, computer, tablet, or smartphone on in the background while your baby is in the room? O Yes O Note of Yes O Note	Have you made arrangements for child care?		O Yes	O No
Coes your partner or do other family members help care for the baby and help around the house? If you have older children, are they getting along with the baby? CARING FOR YOUR BABY S your baby sleeping well? O Yes O Not O Yes O Y	MOTHER'S HEALTH AND FAMILY RELATIONSHIPS			1
f you have older children, are they getting along with the baby? CARING FOR YOUR BABY s your baby sleeping well? O Yes O No Ooes your baby use a pacifier? Can you tell what your baby wants by how she cries? Are you able to calm your baby? s a TV, computer, tablet, or smartphone on in the background while your baby is in the room? O NA O Yes O No O Yes O No O Yes O No	Have you had a post-birth checkup?		O Yes	O No
CARING FOR YOUR BABY s your baby sleeping well? Ooes your baby use a pacifier? Can you tell what your baby wants by how she cries? Are you able to calm your baby? s a TV, computer, tablet, or smartphone on in the background while your baby is in the room? CARING FOR YOUR BABY O Yes O No O Yes O No O Yes O No O Yes	Does your partner or do other family members help care for the baby and help around the house?		O Yes	O No
s your baby sleeping well? O Yes O No Does your baby use a pacifier? O Yes O No Can you tell what your baby wants by how she cries? O Yes O No Are you able to calm your baby? S a TV, computer, tablet, or smartphone on in the background while your baby is in the room? O Yes O No O Yes	If you have older children, are they getting along with the baby?	O NA	O Yes	O No
Does your baby use a pacifier? Can you tell what your baby wants by how she cries? O Yes O No Are you able to calm your baby? S a TV, computer, tablet, or smartphone on in the background while your baby is in the room? O Yes O No O Yes	CARING FOR YOUR BABY			
Can you tell what your baby wants by how she cries? O Yes O No Are you able to calm your baby? S a TV, computer, tablet, or smartphone on in the background while your baby is in the room? O Yes O No O Yes	Is your baby sleeping well?		O Yes	O No
Are you able to calm your baby? S a TV, computer, tablet, or smartphone on in the background while your baby is in the room? O No O Yes	Does your baby use a pacifier?		O Yes	O No
s a TV, computer, tablet, or smartphone on in the background while your baby is in the room? O No O Yes	Can you tell what your baby wants by how she cries?		O Yes	O No
	Are you able to calm your baby?		O Yes	O No
Oo you put your baby on his tummy for short periods of time when he is awake and with you? O Yes O No	Is a TV, computer, tablet, or smartphone on in the background while your baby is in the room?		O No	O Yes
	Do you put your baby on his tummy for short periods of time when he is awake and with you?		O Yes	O No

PATIENT NAME:		DATE:	
	Please print.		

1 MONTH VISIT

CARING FOR YOUR BABY (CONTINUED)

Medical Home After-hours Support					
Do you know how to take your baby's temperature rectally?	O Yes	O No			
Do you know when to call your baby's doctor?	O Yes	O No			
General Information					
Does your baby feed well?	O Yes	O No			
Do you give your baby any supplements, herbs, special teas, or vitamins?	O No	O Yes			
Can you tell when your baby is hungry?	O Yes	O No			
Can you tell when your baby is full?	O Yes	O No			
Do you ever prop the bottle rather than holding it or put your baby to bed with a bottle?	O No	O Yes			
Are you able to burp your baby?	O Yes	O No			
If you are breastfeeding, answer these questions.					
Is breastfeeding uncomfortable or painful?	O No	O Yes			
Do you eat foods high in protein (such as eggs, lean meat, poultry, fish, or beans) every day?	O Yes	O No			
Are you continuing to take prenatal vitamins?	O Yes	O No			
Do you take medications (either over-the-counter or prescription) or herbal supplements?	O No	O Yes			
Are you giving your baby vitamin D drops?	O Yes	O No			
If you are formula feeding, or providing formula supplementation, answer these questions.					
Are you using iron-fortified formula?	O Yes	O No			
Do you have any questions about using formula, such as how much it costs or how to prepare it?	O No	O Yes			

SAFETY

Car and Home Safety						
Is your baby fastened securely in a rear-facing car safety seat in the back seat every time she rides in a vehicle?						
Are you having any problems with your car safety seat?						
Do you always keep one hand on your baby when changing diapers or clothing on a changing table, couch, or bed?						
Do you have emergency phone numbers near every telephone and in your cell phone for rapid dial?						
Safe Sleep						
Does your baby sleep on his back?	O Yes	O No				
Does your baby sleep in a crib?						
Does your baby sleep in your room?	O Yes	O No				

Consistent with Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, 4th Edition

For more information, go to https://brightfutures.aap.org.



The information contained in this questionnaire should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances. Original questionnaire included as part of the *Bright Futures Tool and Resource Kit*, 2nd Edition.

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