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 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.

Your Baby and Family	❑ 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
Your Changing and Developing Baby	❑ How your baby is learning ❑ Games and toys that help your baby learn ❑ Your baby's nighttime routine ❑ Waking up at night ❑ Crying with new people
Feeding Your Baby	❑ Baby feeding himself ❑ Adding solid and table food ❑ Increasing the thickness of foods ❑ Using a cup ❑ Continuing breastfeeding and formula-feeding ❑ Your baby's weight
Safety	❑ 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

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
	Do your child's eyes appear unusual or seem to cross, drift, or be lazy?	❑ Yes	❑ No	❑ Unsure
	Do your child's eyelids droop or does one eyelid tend to close?	❑ Yes	❑ No	❑ Unsure
	Have your child's eyes ever been injured?	❑ 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
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

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?

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.

- ❑ 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