# Prenatal Visit

ID#

Date:

Name: ______________________________

Phone: ______________________________

Expected due date: ______________________________

Bright Futures

## Questions for Parent

- How has your pregnancy gone? What has been the most exciting aspect?
- How are your preparations for your baby going?
- Who will help you when you come home with your baby?
- Do you have other children? Have you talked with them about your pregnancy? Who will look after them while you are in the hospital?
- Many expectant parents have concerns about the baby or themselves. Do you have any concerns?
- Have you had any physical or emotional problems during the pregnancy?
- How do you plan to feed your baby? Breastfeeding? Formula? Why?
- What have you decided to do about circumcision if your baby is a boy?
- Was this a good time for you to be pregnant? How does your family feel about it?
- How do you think the baby will change your lives?
- Do you plan to raise your baby the way you were raised or somewhat differently? What would you change?
- Are you concerned that your child will inherit any diseases or other characteristics that run in the family?
- Have you been offered HIV testing?
- Do you smoke? Do you drink? Have you taken any drugs? Does your partner?
- Do you plan to return to work? To school? Have you thought about child care arrangements?
- Are you concerned about being able to afford food or supplies for your baby?
- Ask the mother privately: Does your partner ever lose his temper, throw things, threaten you, or hurt you?

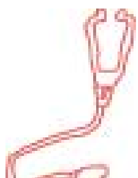
## Family's Questions

- What questions or concerns would you like to discuss today?

______________________________

______________________________

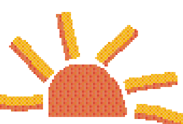
## Notes:



# Prenatal Visit

Date:

Name: ______________________________




## Anticipatory Guidance

### Healthy habits

- ☐ Car seat
- ☐ Crib safety
- ☐ No baby walkers
- ☐ Water temperature <120°
- ☐ Smoke detectors
- ☐ Smoke-free environment
- ☐ Smoking cessation
- ☐ No drugs, alcohol
- ☐ Breastfeeding/bottlefeeding
- ☐ No bottle in bed
- ☐ See dentist
- ☐ Prenatal appointments
- ☐ Childbirth classes
- ☐ Infant CPR

### Family relationships

- ☐ Changes in family relationships
- ☐ Share infant care
- ☐ Prepare siblings for baby
- ☐ Postpone nonessential tasks
- ☐ Fatigue, depression, baby blues
- ☐ Support system

## Closing the Visit

- Summarize visit.
- Offer materials for review at home on child safety, childproofing home, breastfeeding.
- Suggest resources to help with breastfeeding.
- Discuss plans for assessing the baby in the hospital.
- Provide information about parenting classes or support groups.
- Suggest community resources.
- Discuss how to access health care.

## Referral

| Referral | Phone Numbers | |
|---|---|---|
| Health Insurance | ____________ | ☐ |
| SSI | ____________ | ☐ |
| WIC | ____________ | ☐ |
| Food Stamps | ____________ | ☐ |
| Social Services | ____________ | ☐ |
| Housing | ____________ | ☐ |
| Other: | | |

## Notes:

Signature: ______________________________

# Newborn Visit

ID#
Date:

Name: ______________________________

DOB: ______________ Sex: ______________

Parent Name: ______________ Phone: ______________

**Bright Futures**

| Wt. (____ %) | Length (____ %) | HC | T | P | R | BP |
|---|---|---|---|---|---|---|
| | | | | | | |

## Questions for Parent

- Congratulations on your new baby! _____ is doing well and weighs _____ today.
- How are you feeling? How did the delivery go?
- What do your other children think about the new baby?
- What are your questions about feeding?
- Who will help you when you get home?
- What are some of your family's traditions?
- When you have questions about the baby, who do you expect to ask?

## Family's Questions

- What questions or concerns would you like to discuss today?

______________________________

______________________________

## Interval History

Medications: ______________________________

______________________________

Allergies: ______________________________

Recent injury/illness: ______________________________

______________________________

Special health care needs: ______________________________

______________________________

Visits to other health care providers, facilities: ______________

______________________________

Changes/stressors in family or home: ______________

## Physical Exam

| | Normal |
|---|---|
| General | ☐ |
| Skin mottling, toxic erythema, hemangiomas, nevi, mongolian spots, birthmarks | ☐ |
| Peripheral cyanosis | ☐ |
| Cranial molding, cephalohematoma, or caput-succedaneum | ☐ |
| Red reflex | ☐ |
| Subconjunctival hemorrhages | ☐ |
| Puffy eyes | ☐ |
| Ears | ☐ |
| Nose/throat | ☐ |
| Patent nares | ☐ |
| Mouth | ☐ |
| Palate | ☐ |
| Neck | ☐ |
| Clavicle fractures | ☐ |
| Lungs | ☐ |
| Breast engorgement | ☐ |
| Heart | ☐ |
| Abdominal masses or distention | ☐ |
| Back | ☐ |
| Genitalia | ☐ |
| Hernia | ☐ |
| Hip dysplasia | ☐ |
| Femoral pulses | ☐ |
| Extremities | ☐ |
| Feet | ☐ |
| Neurologic | ☐ |
| Reflexes | ☐ |
| Moro reflex, muscle tone, symmetrical movements | ☐ |
| Ability to fix and follow a human face and respond to human voice, and other newborn abilities | ☐ |
| ***Special consideration:*** | |
| Jaundice | ☐ |
| Umbilicus | ☐ |
| Jitteriness | ☐ |
| Urinary stream | ☐ |

If abnormal, explain:

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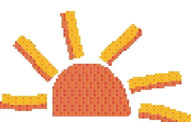
## Notes:

# Newborn Visit

Date:

Name: ____________________



**Bright Futures**

## Anticipatory Guidance

### Healthy habits

- ☐ Car seat
- ☐ Crib safety
- ☐ Sleep on back
- ☐ Water temperature <120°
- ☐ Keep hand on baby
- ☐ Smoke-free environment
- ☐ Smoke detectors
- ☐ Hot liquids, cigarettes
- ☐ Know signs of illness
- ☐ Emergency procedures

### Nutrition

- ☐ Successful breastfeeding practices (holding, latching on, feeding on cue)
- ☐ 6–8 wet diapers a day
- ☐ Maternal care (rest, nipple care, eating properly, followup support)
- ☐ Formula (preparation, techniques, equipment, semi-sitting position)
- ☐ No bottle in bed or microwave

### Infant care

- ☐ Cord, circumcision care
- ☐ Vaginal discharge, bleeding
- ☐ Skin, nails
- ☐ Crying
- ☐ Sneezing, hiccups
- ☐ Burping, spitting up
- ☐ Thumbsucking, pacifiers
- ☐ Sleep patterns, arrangements
- ☐ Meconium to transitional stools
- ☐ Thermometer use
- ☐ Layers of clothing

### Parent/infant interaction

- ☐ Baby's temperament
- ☐ Console baby
- ☐ Hold, cuddle, rock
- ☐ Talk, sing

### Family relationships

- ☐ Partner involvement
- ☐ Rest, fatigue, depression
- ☐ Support from family/friends
- ☐ Siblings' reactions

## Screening

Hearing R__________ L__________

Hemoglobinopathy __________

Metabolic__________

PKU __________

## Immunizations

Side effects discussed?

Hepatitis B # _____ ☐

## Closing the Visit

- Summarize visit.
- Prepare family for next visit, schedule.
- Arrange phone followup 1–3 days.
- Suggest strengths of family, baby.
- Offer resources to help with breastfeeding.
- Arrange continuing care for mother and child.
- Discuss how to access health care.

____________________

____________________

____________________

## Referral

| Referral | Phone Numbers | |
|---|---|---|
| Health Insurance | __________ | ☐ |
| SSI | __________ | ☐ |
| WIC | __________ | ☐ |
| Food Stamps | __________ | ☐ |
| Social Services | __________ | ☐ |
| Housing | __________ | ☐ |
| Other: | | |

## Notes:

Signature:____________________

# 1 Week Visit

ID# | Date:

Name: ____________________

DOB: ____________ Sex: ____________

Parent Name: ____________ Phone: ____________

Bright Futures

| Wt. (___ %) | Length (___ %) | HC | T | P | R | BP |
|---|---|---|---|---|---|---|
| | | | | | | |

## Questions for Parent

- How would you describe _____'s personality?
- Is _____ easy or difficult to console?
- Can you tell when _____ wants to eat or sleep?
- If breastfeeding: How often and for how long do you breastfeed?
- If bottlefeeding: How many ounces are consumed per feeding? What is the total for 24 hours?
- Do you have any concerns about feeding?
- Have you been feeling tired or blue? Who do you turn to at times like that?

## Developmental Observation

**Circle all that apply:**

Responds to sound by startling, blinking, crying, quieting, or changing breathing; looks at faces and follows with eyes; responds to parent's face and voice; has flexed posture.

## Family's Questions

- What questions or concerns would you like to discuss today?

____________________

____________________

## Notes:

## Interval History

Medications: ____________________

____________________

Allergies: ____________________

Recent injury/illness: ____________________

____________________

Special health care needs: ____________________

____________________

Visits to other health care providers, facilities: ____________

____________________

Changes/stressors in family or home: ____________

____________________

## Physical Exam

| | Normal | | |
|---|---|---|---|
| General | ☐ | Genitalia | ☐ |
| Skin | ☐ | Hernia | ☐ |
| Head | ☐ | Hip dysplasia | ☐ |
| Eyes (red reflex, strabismus) | ☐ | Extremities | ☐ |
| | | Feet | ☐ |
| Ears | ☐ | Neurologic | ☐ |
| Nose/throat | ☐ | Reflexes | ☐ |
| Mouth | ☐ | Signs of abuse | ☐ |
| Neck | ☐ | ***Special consideration:*** | |
| Lungs | ☐ | Jaundice | ☐ |
| Heart | ☐ | Umbilicus | ☐ |
| Abdomen | ☐ | Jitteriness | ☐ |
| Back | ☐ | Urinary stream | ☐ |

If abnormal, explain:

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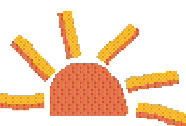
# 1 Week Visit

Date:

Name: ________________________________________

## Bright Futures



## Anticipatory Guidance

### Healthy habits

- ☐ Car seat
- ☐ Crib safety
- ☐ Sleep on back
- ☐ Water temperature <120°
- ☐ Keep hand on baby
- ☐ Smoke-free environment
- ☐ Smoke detectors
- ☐ Hot liquids, cigarettes
- ☐ Know signs of illness
- ☐ Emergency procedures
- ☐ Infant weight gain
- ☐ Breastfeed or iron-fortified formula
- ☐ Avoid honey
- ☐ No bottle in bed
- ☐ Cord, circumcision care
- ☐ Skin, nails
- ☐ Colic, crying
- ☐ Thumbsucking, pacifiers
- ☐ Sleep patterns, arrangements
- ☐ Bowel movements
- ☐ Thermometer use
- ☐ Layers of clothing

### Parent/infant interaction

- ☐ Baby's temperament
- ☐ Console baby
- ☐ Hold, cuddle, rock
- ☐ Talk, sing

### Family relationships

- ☐ Time for self and with partner
- ☐ Fatigue, depression
- ☐ Encourage partner to care for infant
- ☐ Support from family/friends
- ☐ Sibling attention, help out
- ☐ Postpartum checkup

### Community interaction

- ☐ Referrals
- ☐ Parent support groups
- ☐ Community involvement
- ☐ Child care

## Screening

Hearing R____________ L____________

Hemoglobinopathy ____________________

Metabolic____________________________

## Immunizations

Side effects discussed?

Hepatitis B # _____ ☐

## Summary

Summarize visit

Arrange continuing care ____________________

________________________________________

________________________________________

## Referral

| Referral | Phone Numbers | |
|---|---|---|
| Health Insurance | ____________ | ☐ |
| SSI | ____________ | ☐ |
| WIC | ____________ | ☐ |
| Food Stamps | ____________ | ☐ |
| Social Services | ____________ | ☐ |
| Housing | ____________ | ☐ |
| Other: | | |

## Notes:

Signature:________________________________

# 1 Month Visit

ID# ____________ Date: ____________

Name: ______________________________

DOB: ________________ Sex: ________________

Parent Name: ________________ Phone: ________________

**Bright Futures**

| Wt. (____ %) | Length (____ %) | HC | T | P | R | BP |
|---|---|---|---|---|---|---|
| | | | | | | |

## Questions for Parent

- How would you describe _____'s personality?
- What have you found that seems to work during _____'s fussy periods?
- Can you tell when _____ wants to eat or sleep?
- If breastfeeding: How often and for how long do you breastfeed?
- If bottlefeeding: How many ounces are consumed per feeding? What is the total for 24 hours?
- Do you have any concerns about feeding?
- Are you getting enough rest?
- Do you plan to return to work or school?

## Developmental Observation

**Circle all that apply:**

Responds to sound by startling, blinking, crying, quieting, or changing breathing; looks at faces and follows with eyes; responds to parent's face and voice; on stomach, lifts head momentarily; moves arms, legs, and head; can sleep for three or four hours at a time; can stay awake for one hour or longer; when crying, can be consoled most of the time by being spoken to or held.

## Family's Questions

- What questions or concerns would you like to discuss today?

______________________________

______________________________

## Interval History

Medications: ______________________________

______________________________

Allergies: ______________________________

Recent injury/illness: ______________________________

______________________________

Special health care needs: ______________________________

______________________________

Visits to other health care providers, facilities: ______________

______________________________

Changes/stressors in family or home: ______________

______________________________

## Physical Exam

| | Normal | | |
|---|---|---|---|
| General | ☐ | Genitalia | ☐ |
| Skin | ☐ | Hernia | ☐ |
| Head | ☐ | Hip dysplasia | ☐ |
| Eyes (red reflex, strabismus) | ☐ | Extremities | ☐ |
| | | Feet | ☐ |
| Ears | ☐ | Neurologic | ☐ |
| Nose/throat | ☐ | Reflexes | ☐ |
| Mouth | ☐ | Signs of abuse | ☐ |
| Neck | ☐ | ***Special consideration:*** | |
| Lungs | ☐ | Jaundice | ☐ |
| Heart | ☐ | Umbilicus | ☐ |
| Abdomen | ☐ | Jitteriness | ☐ |
| Back | ☐ | Urinary stream | ☐ |

If abnormal, explain:

______________________________

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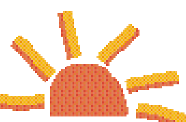
# 1 Month Visit

Date:

Name: ______________________________

**Bright Futures**



## Anticipatory Guidance

### Healthy habits

- ☐ Car seat
- ☐ Sleep on back
- ☐ Water temperature <120°
- ☐ Keep hand on baby
- ☐ Smoke-free environment
- ☐ Smoke detectors
- ☐ Hot liquids, cigarettes
- ☐ Sun exposure
- ☐ Small and sharp objects, plastic bags
- ☐ Know signs of illness
- ☐ Emergency procedures
- ☐ Infant weight gain
- ☐ Breastfeed or iron-fortified formula
- ☐ No cereal in bottle
- ☐ Avoid honey
- ☐ Delay solid foods
- ☐ No bottle in bed
- ☐ Skin, nails
- ☐ Colic, crying
- ☐ Thumbsucking, pacifiers
- ☐ Sleep patterns, arrangements
- ☐ Bowel movements

### Parent/infant interaction

- ☐ Baby's temperament
- ☐ Console baby
- ☐ Hold, cuddle, rock
- ☐ Talk, sing

### Family relationships

- ☐ Partner and sibling involvement
- ☐ Attention to siblings
- ☐ Time for self and with partner
- ☐ Contact with friends, family
- ☐ Family planning

### Community interaction

- ☐ Referrals
- ☐ Play and parent support groups
- ☐ Community involvement
- ☐ Child care

## Screening

Hearing R ________ L ________

Assess lead risk ______________________

## Immunizations

Immunizations up to date? ______________________

Side effects discussed?

Hepatitis B # _____ ☐

## Summary

Summarize visit

Arrange continuing care ______________________

______________________________

______________________________

## Referral

| Referral | Phone Numbers | |
|---|---|---|
| Health Insurance | ____________ | ☐ |
| SSI | ____________ | ☐ |
| WIC | ____________ | ☐ |
| Food Stamps | ____________ | ☐ |
| Social Services | ____________ | ☐ |
| Housing | ____________ | ☐ |
| Other: | | |

## Notes:

Signature: ______________________________

# 2 Month Visit

ID#: Date:

Name: ____________________

DOB: ____________ Sex: ____________

Parent Name: ____________ Phone: ____________

Bright Futures

| Wt. (___ %) | Length (___ %) | HC | T | P | R | BP |
|---|---|---|---|---|---|---|
| | | | | | | |

## Questions for Parent

- What do you and your partner enjoy most about _____?
- How is _____ sleeping? Are you getting enough rest?
- Does _____ have a regular schedule now?
- Have you been out of the house without the baby?
- Do you think _____ hears and sees all right?
- How are your other children?
- Do you have a gun at home? Do you keep it locked in a safe place?

## Developmental Observation

**Circle all that apply:**

Coos and vocalizes reciprocally; pays attention to voices, other sounds, and sights; smiles responsively; shows pleasure with parents; on stomach, lifts head, neck, and upper chest with support on forearms; some head control in upright position.

## Family's Questions

- What questions or concerns would you like to discuss today?

____________________

____________________

## Interval History

Medications: ____________________

____________________

Allergies: ____________________

Recent injury/illness: ____________________

____________________

Special health care needs: ____________________

____________________

Visits to other health care providers, facilities: ____________

____________________

Changes/stressors in family or home: ____________

____________________

## Physical Exam

| | Normal | | |
|---|---|---|---|
| General | ☐ | Abdomen | ☐ |
| Skin | ☐ | Back | ☐ |
| Head | ☐ | Genitalia | ☐ |
| Eyes (red reflex, strabismus) | ☐ | Hernia | ☐ |
| | | Hip dysplasia | ☐ |
| Ears | ☐ | Extremities | ☐ |
| Nose/throat | ☐ | Feet | ☐ |
| Mouth | ☐ | Neurologic | ☐ |
| Neck | ☐ | Reflexes | ☐ |
| Lungs | ☐ | Signs of abuse | ☐ |
| Heart | ☐ | | |

If abnormal, explain:

____________________

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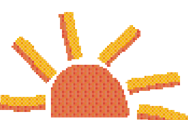
# 2 Month Visit

Date:

Name: ______________________________




## Anticipatory Guidance

### Healthy habits

- ☐ Car seat
- ☐ Sleep on back
- ☐ Water temperature <120°
- ☐ Keep hand on baby
- ☐ Smoke-free environment
- ☐ Smoke detectors
- ☐ Hot liquids, cigarettes
- ☐ Sun exposure
- ☐ Small and sharp objects, plastic bags
- ☐ Know signs of illness
- ☐ Emergency procedures
- ☐ Infant weight gain
- ☐ Breastfeed or iron-fortified formula
- ☐ No cereal in bottle
- ☐ Avoid honey
- ☐ Delay solid foods
- ☐ No bottle in bed
- ☐ Skin, nails
- ☐ Colic, crying
- ☐ Thumbsucking, pacifiers
- ☐ Sleep patterns, arrangements
- ☐ Bowel movements

### Parent/infant interaction

- ☐ Baby's temperament
- ☐ Hold, cuddle, rock
- ☐ Talk, sing, read, play music
- ☐ Toys
- ☐ Bedtime routine

### Family relationships

- ☐ Partner and sibling involvement
- ☐ Attention to siblings
- ☐ Time for self and with partner
- ☐ Contact with friends, family
- ☐ Family planning

### Community interaction

- ☐ Referrals
- ☐ Play and parent support groups
- ☐ Community involvement
- ☐ Child care

## Immunizations

Immunizations up to date? ______________________

| | Side effects discussed? |
|---|---|
| Hepatitis B # _____ | ☐ |
| Diphtheria, tetanus, pertussis # _____ | ☐ |
| *H. influenzae* type b # _____ | ☐ |
| Polio # _____ | ☐ |

## Summary

Summarize visit

Arrange continuing care ______________________

______________________________

______________________________

## Referral

| | Phone Numbers | |
|---|---|---|
| Health Insurance | ______________ | ☐ |
| SSI | ______________ | ☐ |
| WIC | ______________ | ☐ |
| Food Stamps | ______________ | ☐ |
| Social Services | ______________ | ☐ |
| Housing | ______________ | ☐ |
| Other: | | |

## Notes:

Signature: ______________________________

# 4 Month Visit

ID#
Date:

Name: ______________________

DOB: ______________ Sex: ______________

Parent Name: ______________ Phone: ______________

**Bright Futures**

| Wt. (____ %) | Length (____ %) | HC | T | P | R | BP |
|---|---|---|---|---|---|---|
| | | | | | | |

## Questions for Parent

- How is your family getting along?
- Who helps you out with _____?
- Is it easy or difficult to tell what _____ wants or needs?
- Does _____ sleep through the night?
- Have you returned to work or school, or do you plan to do so? What are your child care arrangements?
- Have you and your partner been getting out without the baby?

## Developmental Observation

- How does _____ move around?
- Tell me about _____'s typical play.

**Circle all that apply:**

Babbles and coos; smiles, laughs, and squeals; on stomach, holds head erect and raises body on hands; rolls over from stomach to back; opens hands, holds own hands, grasps rattle; controls head well; reaches for and bats objects; recognizes parent's voice and touch.

## Family's Questions

- What questions or concerns would you like to discuss today?

______________________

______________________

## Interval History

Medications: ______________________

______________________

Allergies: ______________________

Recent injury/illness: ______________________

______________________

Special health care needs: ______________________

______________________

Visits to other health care providers, facilities: ______________

______________________

Changes/stressors in family or home: ______________

______________________

## Physical Exam

| | Normal | | |
|---|---|---|---|
| General | ☐ | Heart | ☐ |
| Skin | ☐ | Abdomen | ☐ |
| Head | ☐ | Back | ☐ |
| Eyes (red reflex, strabismus) | ☐ | Genitalia | ☐ |
| | | Hernia | ☐ |
| Ears | ☐ | Extremities | ☐ |
| Nose/throat | ☐ | Feet | ☐ |
| Mouth | ☐ | Neurologic | ☐ |
| Neck | ☐ | Reflexes | ☐ |
| Lungs | ☐ | Signs of abuse | ☐ |

If abnormal, explain:

______________________

______________________

______________________

______________________

______________________

# 4 Month Visit

Date:

Name: ______________________________________________

## Anticipatory Guidance

### Healthy habits

- ☐ Car seat
- ☐ Sleep on back
- ☐ Water temperature <120°
- ☐ Keep hand on baby
- ☐ Smoke-free environment
- ☐ Hot liquids, cigarettes
- ☐ Sun exposure
- ☐ Childproof home
- ☐ Syrup of Ipecac
- ☐ No baby walkers
- ☐ Know signs of illness
- ☐ Breastfeed or iron-fortified formula
- ☐ Introduce solid food
- ☐ Avoid honey

### Parent/infant interaction

- ☐ Hold, cuddle, rock
- ☐ Talk, sing, play music
- ☐ Games and toys
- ☐ Bedtime routine
- ☐ Comfort objects

### Family relationships

- ☐ Partner and sibling involvement
- ☐ Attention to siblings
- ☐ Time for self and with partner
- ☐ Contact with friends, family

### Community interaction

- ☐ Referrals
- ☐ Play and parent support groups
- ☐ Community involvement

## Immunizations

Immunizations up to date? ______________________

| | Side effects discussed? |
|---|---|
| Hepatitis B # _____ | ☐ |
| Diphtheria, tetanus, pertussis # _____ | ☐ |
| *H. influenzae* type b # _____ | ☐ |
| Polio # _____ | ☐ |

## Summary

Summarize visit

Arrange continuing care ______________________

______________________________________________

______________________________________________

## Referral

| | Phone Numbers | |
|---|---|---|
| Health Insurance | ____________ | ☐ |
| SSI | ____________ | ☐ |
| WIC | ____________ | ☐ |
| Food Stamps | ____________ | ☐ |
| Social Services | ____________ | ☐ |
| Housing | ____________ | ☐ |
| Other: | | |

## Notes:

Signature: ______________________________________

# 6 Month Visit

ID# | Date:

Name: ____________________

DOB: ____________ Sex: ____________

Parent Name: ____________ Phone: ____________

Bright Futures

| Wt. (____ %) | Length (____ %) | HC | T | P | R | BP |
|---|---|---|---|---|---|---|
| | | | | | | |

## Questions for Parent

- How does _____ spend his day?
- Have you introduced solid foods? What is _____ eating? Has he had any reactions?
- Do you think _____ hears all right? Does his head turn when you walk into the room?
- How are you balancing your roles of partner and parent?
- Do you have a reliable person to care for your baby when you need to go out?
- What language do you speak at home?

## Developmental Observation

- How does _____ communicate?
- How does _____ act around other people?

**Circle all that apply:**

Says "dada" or "baba"; babbles reciprocally; rolls over; has no head lag when pulled to sit; sits with support; stands when placed; grasps and mouths objects; shows differential recognition of parents; transfers cubes from hand to hand; rakes in small objects; self-comforts; smiles, laughs, squeals, imitates razzing noise; turns to sounds; may have first tooth.

## Family's Questions

- What questions or concerns would you like to discuss today?

____________________

____________________

## Interval History

Medications: ____________________

____________________

Allergies: ____________________

Recent injury/illness: ____________________

____________________

Special health care needs: ____________________

____________________

Visits to other health care providers, facilities: ____________________

____________________

Changes/stressors in family or home: ____________________

____________________

## Physical Exam

| | Normal | | Normal |
|---|---|---|---|
| General | ☐ | Abdomen | ☐ |
| Skin | ☐ | Back | ☐ |
| Head | ☐ | Genitalia | ☐ |
| Eyes (red reflex, strabismus) | ☐ | Hernia | ☐ |
| Ears | ☐ | Extremities | ☐ |
| Nose/throat | ☐ | Feet | ☐ |
| Mouth | ☐ | Muscle tone | ☐ |
| Neck | ☐ | Neurologic | ☐ |
| Lungs | ☐ | Reflexes | ☐ |
| Heart | ☐ | Signs of abuse | ☐ |

If abnormal, explain:

____________________

____________________

____________________

____________________

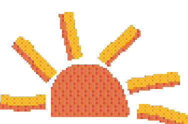
____________________

# 6 Month Visit

Date:

Name: ____________________

**Bright Futures**



## Anticipatory Guidance

### Healthy habits

- ☐ Check hazards
- ☐ Car seat
- ☐ Sleep on back
- ☐ Water temperature <120°
- ☐ Keep hand on baby
- ☐ Empty buckets
- ☐ Smoke-free environment
- ☐ Hot liquids, cigarettes
- ☐ Sun exposure
- ☐ Childproof home
- ☐ Syrup of Ipecac
- ☐ No baby walkers
- ☐ First aid, CPR
- ☐ Know signs of illness
- ☐ Breastfeed or iron-fortified formula
- ☐ Introduce solid food
- ☐ Avoid choke foods
- ☐ Supervise eating
- ☐ Start cup for water, juice
- ☐ Avoid honey
- ☐ No bottle in bed
- ☐ Brush teeth
- ☐ Fluoride

### Parent/infant interaction

- ☐ Talk, sing, read, play music
- ☐ Pat-a-cake, peekaboo
- ☐ Exploration opportunities
- ☐ Use distraction as discipline
- ☐ Limit but enforce rules
- ☐ Bedtime routine
- ☐ Comfort objects

### Family relationships

- ☐ Sibling involvement
- ☐ Contact with friends, family
- ☐ Role model healthy habits

### Community interaction

- ☐ Referrals
- ☐ Community involvement

## Screening

Anemia (if WIC) ____________________

Assess lead risk ____________________

**If risk:**
Lead ____________________

## Immunizations

Immunizations up to date? ____________________

| | Side effects discussed? |
|---|---|
| Hepatitis B # _____ | ☐ |
| Diphtheria, tetanus, pertussis # _____ | ☐ |
| *H. influenzae* type b # _____ | ☐ |
| Polio # _____ | ☐ |

## Summary

Summarize visit

Arrange continuing care ____________________

____________________

____________________

## Referral

| | Phone Numbers | |
|---|---|---|
| Health Insurance | __________ | ☐ |
| SSI | __________ | ☐ |
| WIC | __________ | ☐ |
| Food Stamps | __________ | ☐ |
| Social Services | __________ | ☐ |
| Housing | __________ | ☐ |
| Other: | | |

## Notes:

Signature: ____________________

# 9 Month Visit

ID#
Date:

Name: ______________________

DOB: ______________ Sex: ______________

Parent Name: ______________ Phone: ______________

Bright Futures

| Wt. (____ %) | Length (____ %) | HC | T | P | R | BP |
|---|---|---|---|---|---|---|
| | | | | | | |

## Questions for Parent

- What is _____ eating?
- Does _____ awaken at night?
- Now that _____ can move on her own more, what changes have you made in your home to ensure her safety?
- How does it feel to have _____ become more independent?
- Does _____ play in a house with peeling or chipping paint?
- Do you have any time for yourself?

## Developmental Observation

- What do you think _____ understands?
- How does _____ move around?

**Circle all that apply:**

Responds to own name; understands a few words; babbles; crawls, creeps, or scoots; sits; pokes with finger; shakes, bangs, throws, and drops objects; plays peekaboo or pat-a-cake; feeds self with fingers; may show anxiety with strangers.

## Family's Questions

- What questions or concerns would you like to discuss today?

______________________

______________________

## Interval History

Medications: ______________________

______________________

Allergies: ______________________

Recent injury/illness: ______________________

______________________

Special health care needs: ______________________

______________________

Visits to other health care providers, facilities: ______________________

______________________

Changes/stressors in family or home: ______________________

______________________

## Physical Exam

| | Normal | | |
|---|---|---|---|
| General | ☐ | Heart | ☐ |
| Skin | ☐ | Abdomen | ☐ |
| Head | ☐ | Back | ☐ |
| Eyes (red reflex, strabismus) | ☐ | Genitalia | ☐ |
| Ears | ☐ | Hernia | ☐ |
| Nose/throat | ☐ | Extremities | ☐ |
| Mouth | ☐ | Feet | ☐ |
| Teeth | ☐ | Neurologic | ☐ |
| Neck | ☐ | Reflexes | ☐ |
| Lungs | ☐ | Signs of abuse | ☐ |

If abnormal, explain:

______________________

______________________

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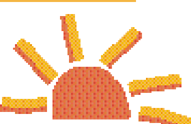
______________________

# 9 Month Visit

Date:

Name: ______________________________

## Bright Futures



## Anticipatory Guidance

### Healthy habits

- ☐ Check hazards
- ☐ Sleep on back
- ☐ Water temperature <120°
- ☐ Keep hand on baby
- ☐ Empty buckets
- ☐ Smoke-free environment
- ☐ Hot liquids, cigarettes
- ☐ Sun exposure
- ☐ Childproof home
- ☐ Syrup of Ipecac
- ☐ No baby walkers
- ☐ Finger foods, mashed foods
- ☐ Avoid choke foods
- ☐ Supervise eating
- ☐ Breastfeed or iron-fortified formula
- ☐ Drink from cup
- ☐ No bottle in bed
- ☐ Brush teeth
- ☐ Fluoride

### Parent/infant interaction

- ☐ Talk, sing
- ☐ Pat-a-cake and peekaboo
- ☐ Exploration opportunities
- ☐ Use distraction as discipline
- ☐ Limit but enforce rules
- ☐ Bedtime routine
- ☐ Comfort objects

### Family relationships

- ☐ Partner and sibling involvement
- ☐ Time for self and with partner
- ☐ Contact with friends, family
- ☐ Role model healthy habits

### Community interaction

- ☐ Referrals
- ☐ Community programs
- ☐ Play and parent support groups
- ☐ Community involvement

## Screening

Assess lead risk ______________________________

Lead (or at 12 months) ______________________________

**If risk:**

PPD ______________________________

Hematocrit or hemoglobin ______________________________

## Immunizations

Immunizations up to date? ______________________________

| | Side effects discussed? |
|---|---|
| Hepatitis B #_____ | ☐ |
| Polio # _____ | ☐ |

## Summary

Summarize visit

Arrange continuing care ______________________________

______________________________

______________________________

## Referral

| | Phone Numbers | |
|---|---|---|
| Health Insurance | ______________ | ☐ |
| SSI | ______________ | ☐ |
| WIC | ______________ | ☐ |
| Food Stamps | ______________ | ☐ |
| Social Services | ______________ | ☐ |
| Housing | ______________ | ☐ |
| Other: | | |

## Notes:

Signature: ______________________________

# 1 Year Visit

ID#
Date:

Name: ____________________

DOB: ____________ Sex: ____________

Parent Name: ____________ Phone: ____________

Bright Futures

| Wt. (____ %) | Length (____ %) | HC | T | P | R | BP |
|---|---|---|---|---|---|---|
| | | | | | | |

## Questions for Parent

- What is _____ eating?
- Does _____ sleep through the night?
- What are your thoughts about discipline? Do you and your partner tend to agree?
- Does _____ have an object or a favorite toy she uses to comfort herself?
- What are some of your family's traditions?
- Have you childproofed your home? Are household cleaners and poisonous items locked or stored out of _____'s sight and reach?
- Do you have smoke alarms in your home? Have you checked the batteries recently?

## Developmental Observation

- How does _____ get from one place to another?
- To what extent does _____ eat independently?

**Circle all that apply:**

Pulls to stand, cruises, and may take a few steps alone; plays pat-a-cake, peekaboo, or so-big; points; bangs blocks together; says 2–4 words, imitates vocalizations; drinks from cup; looks for dropped or hidden objects; waves "bye-bye"; feeds self.

## Family's Questions

- What questions or concerns would you like to discuss today?

____________________

____________________

## Interval History

Medications: ____________________

____________________

Allergies: ____________________

Recent injury/illness: ____________________

____________________

Special health care needs: ____________________

____________________

Visits to other health care providers, facilities: ____________

____________________

Changes/stressors in family or home: ____________

____________________

## Physical Exam

| | Normal | | |
|---|---|---|---|
| General | ☐ | Heart | ☐ |
| Skin | ☐ | Abdomen | ☐ |
| Head | ☐ | Back | ☐ |
| Eyes (red reflex) | ☐ | Genitalia | ☐ |
| Ears | ☐ | Extremities | ☐ |
| Nose/throat | ☐ | Feet | ☐ |
| Mouth | ☐ | Gait | ☐ |
| Teeth | ☐ | Neurologic | ☐ |
| Neck | ☐ | Reflexes | ☐ |
| Lungs | ☐ | Signs of abuse | ☐ |

If abnormal, explain:

____________________

____________________

____________________

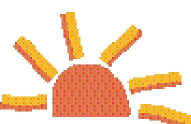
____________________

____________________

# 1 Year Visit

Date:

Name: ______________________________

**Bright Futures** 

## Anticipatory Guidance

### Healthy habits

- ☐ Check hazards
- ☐ Toddler car seat, airbags
- ☐ Bike helmet
- ☐ Water temperature <120°
- ☐ Water safety
- ☐ Sunscreen
- ☐ Childproof home
- ☐ Close supervision
- ☐ Lower crib mattress
- ☐ Family meals
- ☐ Self-feed, drink from cup
- ☐ Healthy food choices, experimentation
- ☐ No forced foods
- ☐ Whole milk
- ☐ Nutritious snacks, limit sugar
- ☐ Avoid choke foods
- ☐ No bottle in bed
- ☐ Brush teeth
- ☐ First dental exam

### Social competence

- ☐ Praise toddler
- ☐ Interactive talking, singing, reading
- ☐ Individual attention
- ☐ Exploration, physical activity
- ☐ Playmates
- ☐ Establish routines
- ☐ Enforce rules
- ☐ Hitting, biting, aggressive behavior
- ☐ Self-care, self-quieting
- ☐ Comfort objects
- ☐ Toilet training
- ☐ Limit TV
- ☐ Curiosity about genitalia

### Family relationships

- ☐ Cuddling, holding, affection
- ☐ Family playtime
- ☐ Help toddler express emotions
- ☐ Limit number of caregivers
- ☐ Role model healthy habits
- ☐ Time for self and with partner

### Community interaction

- ☐ Referrals
- ☐ Community programs, early intervention
- ☐ Community involvement

## Screening

Lead (if not earlier) ______________________________

PPD ______________________________

**If risk:**

Hematocrit or hemoglobin ______________________________

## Immunizations

Immunizations up to date? ______________________________

| | Side effects discussed? |
|---|---|
| Hepatitis B # _____ | ☐ |
| *H. influenzae* type b # _____ | ☐ |
| Polio # _____ | ☐ |
| Measles, mumps, rubella # _____ | ☐ |
| Varicella # _____ | ☐ |

## Summary

Summarize visit

Arrange continuing care ______________________________

______________________________

______________________________

## Referral

| | Phone Numbers | |
|---|---|---|
| Health Insurance | ______________ | ☐ |
| SSI | ______________ | ☐ |
| WIC | ______________ | ☐ |
| Food Stamps | ______________ | ☐ |
| Social Services | ______________ | ☐ |
| Housing | ______________ | ☐ |
| Other: | | |

## Notes:

Signature: ______________________________