4 Month Forms

Patient Name: _____

Bright Futures Previsit Questionnaire
4 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	☐ Taking time for yourself ☐ Having time alone with your partner ☐ Spending time alone with each of your children ☐ Returning to work or school ☐ What is good child care
Your Changing Baby	☐ Where your baby sleeps ☐ How your baby sleeps ☐ How to keep your baby safe while sleeping ☐ Tummy time for playtime with you ☐ How to calm your baby ☐ Keeping daily routines
Feeding Your Baby	☐ Breastfeeding ☐ Formula feeding ☐ How your baby is growing ☐ Starting solid foods ☐ Food allergies ☐ Your child's weight
Healthy Teeth	☐ Using a pacifier ☐ Teething ☐ Drooling ☐ Not using a bottle in bed
Safety	☐ Car safety seats ☐ Preventing falls, burns, and choking ☐ Not using walkers ☐ Drowning and pools ☐ How to check for lead in your home ☐ Checking the hot water heater temperature

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
Anemia	Is your child drinking anything other than breast milk or iron-fortified formula?	☐ Yes	☐ No	☐ Unsure

Does your child have any special health care needs? ☐ No ☐ Yes, describe:

_____

_____

Other than your baby's birth, 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.

- ☐ Smiles to get your attention
- ☐ Keeps head steady when sitting up on your lap
- ☐ Begins to roll and reach for objects
- ☐ Wants you to play
- ☐ Can calm down on his own
- ☐ Likes to cuddle
- ☐ Lets you know when she likes something
- ☐ Lets you know when he does not like something
- ☐ Uses arms to lift chest
- ☐ Babbling

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

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Edinburgh Postnatal Depression Scale[1] (EPDS)

Mother's Name: _____ Baby's Name:_____

Mother's Date of Birth: _____ Baby's Date of Birth: _____

Phone: _____ OBGYN:_____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:

□ Yes, all the time
☒ Yes, most of the time This would mean: "I have felt happy most of the time" during the past week. No, not
□ very often Please complete the other questions in the same way.
□ No, not at all

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - □ As much as I always could
   - □ Not quite so much now
   - □ Definitely not so much
   - □ now Not at all

2. I have looked forward with enjoyment to things
   - □ As much as I ever did
   - □ Rather less than I used to
   - □ Definitely less than I used
   - □ to Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - □ Yes, most of the time
   - □ Yes, some of the
   - □ time Not very often
   - □ No, never

4. I have been anxious or worried for no good reason
   - □ No, not at all
   - □ Hardly ever
   - □ Yes,
   - □ sometimes
     Yes, very often

*5 I have felt scared or panicky for no very good reason
   - □ Yes, quite a lot
   - □ Yes,
   - □ sometimes No,
   - □ not much No,
     not at all

*6. Things have been getting on top of me
   - □ Yes, most of the time I haven't been able to cope at all
   - □ Yes, sometimes I haven't been coping as well as usual
   - □ No, most of the time I have coped quite well
   - □ No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - □ Yes, most of the
   - □ time Yes, sometimes
   - □ Not very often
   - □ No, not at all

*8 I have felt sad or miserable
   - □ Yes, most of the
   - □ time Yes, quite often
   - □ Not very often
   - □ No, not at all

*9 I have been so unhappy that I have been crying
   - □ Yes, most of the
   - □ time Yes, quite often
   - □ Only occasionally
   - □ No, never

*10 The thought of harming myself has occurred to me
   - □ Yes, quite
   - □ often
   - □ Sometimes
   - □ Hardly ever
     Never

Administered/Reviewed by _____ Date _____