



Bright Futures Parent Supplemental Questionnaire

2 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 circle Yes or No for each question. Thank you.

How You Are Feeling: Parental Well-being

| | | | |
|--|-----|-----|----|
| Are you getting enough rest? | | Yes | No |
| Have you been out of the house without your baby? | | Yes | No |
| Do you have someone who you can trust to look after your baby? | | Yes | No |
| Do other family members and friends help you take care of your baby? | | Yes | No |
| Do you and your partner spend time together? | | Yes | No |
| Are you able to spend time alone with your older children? | N/A | Yes | No |
| Have you had a post-birth checkup? | | Yes | No |

Your Growing Baby: Infant Behavior

| | | | |
|---|--|-------------|----|
| Do you enjoy caring for your baby? | | Yes | No |
| Do you cuddle, talk, and play with your baby? | | Yes | No |
| Does your baby have a regular schedule for naps and sleeping? | | Yes | No |
| Can your baby sleep for 4–5 hours at night? | | Yes | No |
| Does your baby sleep on his back? | | Yes | No |
| Does your baby sleep in a crib? | | Yes | No |
| Does your baby spend time with you on her tummy when awake? | | Yes | No |
| Are you able to calm your baby? | | Yes | No |
| Can you tell what your baby wants by how he cries? | | Yes | No |
| How many hours per day does your baby watch TV? | | _____ hours | |

Your Baby and Family: Infant-Family Synchrony

| | | | |
|--|--|-----|----|
| Do you feel comfortable leaving your baby with someone else? | | Yes | No |
| If you plan on returning to school or work, have you found child care? | | Yes | No |



Feeding Your Baby: Nutritional Adequacy

| | | | |
|--|-------------|---------|------|
| Can you tell when your baby is hungry? | Yes | No | |
| Can you tell when your baby is full? | Yes | No | |
| What are you feeding your baby? | Breast Milk | Formula | Both |
| Do you have any questions about pumping and storing breast milk? | No | Yes | |
| Do you have a feeding routine? | Yes | No | |

Safety

| | | |
|---|-----|-----|
| Do you always use a car safety seat? | Yes | No |
| Is your baby's car safety seat always rear-facing in the back seat of the car? | Yes | No |
| Are you having any problems with your car safety seat? | No | Yes |
| Are your home and car smoke free? | Yes | No |
| Does anyone smoke around your child? | No | Yes |
| If you smoke, would you like information on how to stop? | Yes | No |
| Do you always keep one hand on your baby when changing her diaper? | Yes | No |
| Is your hot water temperature at or below 120°F at the faucet? | Yes | No |
| Do you keep plastic bags and latex balloons away from your baby to prevent choking? | Yes | No |
| Do you ever drink or carry hot liquids when holding your baby? | No | Yes |



**American Academy
of Pediatrics**



DEDICATED TO THE HEALTH OF ALL CHILDREN™

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