Bright Futures Parent Handout
4 Month Visit

Here are some suggestions from Bright Futures experts that may be of value to your family.

FAMILY FUNCTIONING

How Your Family Is Doing

- Take time for yourself.
- Take time together with your partner.
- Spend time alone with your other children.
- Encourage your partner to help care for your baby.
- Choose a mature, trained, and responsible babysitter or caregiver.
- You can talk with us about your child care choices.
- Hold, cuddle, talk to, and sing to your baby each day.
- Massaging your infant may help your baby go to sleep more easily.
- Get help if you and your partner are in conflict. Let us know. We can help.

NUTRITIONAL ADEQUACY AND GROWTH

Feeding Your Baby

- Feed only breast milk or iron-fortified formula in the first 4–6 months.

If Breastfeeding

- If you are still breastfeeding, that's great!
- Plan for pumping and storage of breast milk.

If Formula Feeding

- Make sure to prepare, heat, and store the formula safely.
- Hold your baby so you can look at each other while feeding.
- Do not prop the bottle.
- Do not give your baby a bottle in the crib.

Solid Food

- You may begin to feed your baby solid food when your baby is ready.
- Some of the signs your baby is ready for solids
  - Opens mouth for the spoon.
  - Sits with support.
  - Good head and neck control.
  - Interest in foods you eat.
- Avoid foods that cause allergy—peanuts, tree nuts, fish, and shellfish.
- Avoid feeding your baby too much by following the baby's signs of fullness
  - Leaning back
  - Turning away
- Ask us about programs like WIC that can help get food for you if you are breastfeeding and formula for your baby if you are formula feeding.

NUTRITION

SAFETY

Safety

- Use a rear-facing car safety seat in the back seat in all vehicles.
- Always wear a seat belt and never drive after using alcohol or drugs.
- Keep small objects and plastic bags away from your baby.
- Keep a hand on your baby on any high surface from which she can fall and be hurt.
- Prevent burns by setting your water heater so the temperature at the faucet is 120°F or lower.
- Do not drink hot drinks when holding your baby.
- Never leave your baby alone in bathwater, even in a bath seat or ring.
- The kitchen is the most dangerous room. Don't let your baby crawl around there; use a playpen or high chair instead.
- Do not use a baby walker.

INFANT DEVELOPMENT

Your Changing Baby

- Keep routines for feeding, nap time, and bedtime.

Crib/Playpen

- Put your baby to sleep on her back.
  - In a crib that meets current safety standards, with no drop-side rail and slats no more than 2 3/8 inches apart. Find more information on the Consumer Product Safety Commission Web site at www.cpsc.gov.
  - If your crib has a drop-side rail, keep it up and locked at all times. Contact the crib company to see if there is a device to keep the drop-side rail from falling down.
  - Keep soft objects and loose bedding such as comforters, pillows, bumper pads, and toys out of the crib.
  - Lower your baby's mattress.
  - If using a mesh playpen, make sure the openings are less than ¼ inch apart.

INFANT DEVELOPMENT

Playtime

- Learn what things your baby likes and does not like.
- Encourage active play.
  - Offer mirrors, floor gyms, and colorful toys to hold.
  - Tummy time—put your baby on his tummy when awake and you can watch.
- Promote quiet play.
  - Hold and talk with your baby.
  - Read to your baby often.

Crying

- Give your baby a pacifier or his fingers or thumb to suck when crying.

ORAL HEALTH

Healthy Teeth

- Go to your own dentist twice yearly. It is important to keep your teeth healthy so that you don't pass bacteria that causes tooth decay on to your baby.
- Do not share spoons or cups with your baby or use your mouth to clean the baby's pacifier.
- Use a cold teething ring if your baby has sore gums with teething.

What to Expect at Your Baby's 6 Month Visit

We will talk about

- Introducing solid food
- Getting help with your baby
- Home and car safety
- Brushing your baby's teeth
- Reading to and teaching your baby

Poison Help: 1-800-222-1222

Child safety seat inspection:
1-866-SEATCHECK; seatcheck.org

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

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

MARYLAND HEALTHY KIDS PROGRAM

Preventive Screen Questionnaire

Anemia Screening (Starting at 11 years of age and annually thereafter)	Date ____	Date ____	Date ____	Date ____	Date ____	Date ____	Date ____
1. (FEMALES AND MALES) Does the child/adolescent's diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
2. (FEMALES AND MALES) Have you ever been diagnosed with iron deficiency anemia?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
3. (FEMALES ONLY) Do you have excessive menstrual bleeding or other blood loss?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
4. (FEMALES ONLY) Does your period last more than 5 days?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
Heart Disease/Cholesterol Risk Assessment: *(2 years through 20 years)*	Date ____	Date ____	Date ____	Date ____	Date ____	Date ____	Date ____
1. Is there a family history of parents/grandparents under 55 years of age with a heart attack, heart surgery, angina or sudden cardiac death?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
2. Has the child's mother or father been diagnosed with high cholesterol (240 mg/dL or higher)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
3. Is the child/adolescent overweight (BMI > 85th %)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
4. And is there a personal history of:							
Smoking?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
Lack of physical activity?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
High blood pressure?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
High cholesterol?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
Diabetes mellitus?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
(Refer to the AAP Clinical Guidelines for Childhood Lipid Screening)	Date ____	Date ____	Date ____	Date ____	Date ____	Date ____	Date ____
STI/HIV Risk Assessment: *(11 years through 20 years)*							
1. Are you sexually active?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
2. If sexually active, have you had more than one partner?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
3. If sexually active, have you had unprotected sex, with opposite/same sex?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
4. Have you ever been sexually molested or physically attacked?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
5. Have you ever been diagnosed with any sexually transmitted diseases?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
6. Any body tattoos or body piercing of ears, navel, etc., including any performed by friends?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
7. Have you had a blood transfusion or are you a Hemophiliac?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
8. Any history of IV drug use by you, your sex partner, or your birth mother during pregnancy?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N

A "yes" response or "don't know" to any question indicates a positive risk)

Patient Name: _____ **Birth Date:** _____

https://mmcp.dhmh.maryland.gov/epsdt/Pages/Home.aspx

Updated 10/17

MARYLAND HEALTHY KIDS PROGRAM

Preventive Screen Questionnaire

Lead Risk Assessment: *(every well child visit from 6 months up to 6 years)*	Date ____	Date ____	Date ____	Date ____	Date ____	Date ____	Date ____
1. Has your child ever lived or stayed in a house or apartment that is built before 1978 (Includes day care center, preschool home, home of babysitter or relative)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
2. Has your child ever lived outside the United States or recently arrived from a foreign country?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
3. Is anyone in the home being treated or followed for lead poisoning?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
4. Are there any current renovations or peeling paint in a home that your child regularly visits?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
5. Does your child lick, eat, or chew things that are not food (paint chips, dirt, railings, poles, furniture, old toys, etc.)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
6. Is there any family member who is currently working in an occupation or hobby where lead exposure could occur (auto mechanic, ceramics, commercial painter, etc.)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
7. Does your family use products from other countries such as health remedies, traditional remedies, spices, cosmetics or other products canned or packaged outside of the United States? Or store or serve food in leaded crystal, pottery or pewter? **Examples:** Glazed pottery, Greta, Azarcon (Rueda, Coral, Liga), Litargirio, Surma, Kohl (Al kohl), Pay-loo-ah, Ayurvedic medicine, Ghassard).	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
Tuberculosis Risk Assessment: *(Starting at 1 months of age and annually thereafter)*	Date ____	Date ____	Date ____	Date ____	Date ____	Date ____	Date ____
1. Has your child been exposed to anyone with a case of TB or a positive tuberculin skin test, or received a tuberculosis vaccination?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
2. Was your child, or a household member, born in a high-risk country (countries other than the United States, Canada, Australia, New Zealand, or Western and North European countries)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
3. Has your child travelled (had a contact with resident populations) to a high-risk country for more than 1 week?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
4. Does your child have daily contact with adults at high risk for TB (e.g., those who are HIV infected, homeless, incarcerated, and/or illicit drug users)?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
5. Does your child have HIV infection?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N

(A "yes" response or "don't know" to any question indicates a positive risk)

Patient Name: _____ **Birth Date:** _____

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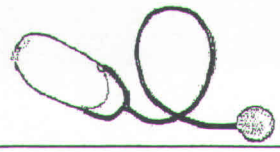
Updated 10/17



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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name: _____ **Date:** _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use "x" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
1) Little interest or pleasure in doing things	☐	☐	☐	☐
2) Feeling down, depressed, or hopeless	☐	☐	☐	☐
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	☐	☐	☐	☐

Total Score: _____

Interpretation

- ☐ Minimal Depression
- ☐ Mild Depression
- ☐ Moderate Depression
- ☐ Moderately Severe Depression
- ☐ Severe Depression

Interpretation of Total Score for Depression Severity

- 1-4 Minimal depression
- 5-9 Mild depression
- 10-14 Moderate depression
- 15-19 Moderately severe depression
- 20-27 Severe depression