2 Month Questionnaire

Patient's Name: _____

Personal/Social History

Are you concerned about your baby's…

1. Feedings? ☐ Yes ☐ No
   ☐ Breast ☐ Formula
2. Excessive spitting, vomiting, or back arching with feedings? ☐ Yes ☐ No
3. Bowel movements? ☐ Yes ☐ No
4. Nasal stuffiness, congestion or wheezing? ☐ Yes ☐ No
5. Skin color or rashes (circle one)? ☐ Yes ☐ No
6. Crying more than 3 hours a day? ☐ Yes ☐ No
7. Sleep habits ☐ Yes ☐ No
8. Growth ☐ Yes ☐ No
9. Development? ☐ Yes ☐ No

Answer the following:

10. Is your child exposed to tobacco smoke? ☐ Yes ☐ No
11. Have you been depressed or crying lately? ☐ Yes ☐ No
12. Are your infants bowel movements white or gray or blood streaked? ☐ Yes ☐ No
13. Does your baby co-sleep with you? ☐ Yes ☐ No
14. Has your child traveled out of the country or do you plan to take your child to a country OTHER THAN Western Europe, Canada, Australia, or New Zealand in the next year? ☐ Yes ☐ No

Does your child…

15. Smile at the sound of your voice or seeing your face? ☐ Yes ☐ No
16. Coo or vocalize when you talk to him/her? ☐ Yes ☐ No
17. Watch you as you walk across the room? ☐ Yes ☐ No
18. Startle at loud noises? ☐ Yes ☐ No
19. Turn his/her head toward the direction of sound? ☐ Yes ☐ No
20. Move all extremities equally well? ☐ Yes ☐ No
21. Hold head upright for a short time? ☐ Yes ☐ No
22. Bottle fed infants: Is your child getting over 30 ounces per day? ☐ Yes ☐ No

Answer the following:

23. Do you have any help with the baby? ☐ Yes ☐ No
24. Are you getting enough rest? ☐ Yes ☐ No
25. Does your child ride in a rear-facing infant car seat? ☐ Yes ☐ No
26. Do you know infant CPR? ☐ Yes ☐ No
27. Does your baby sleep with a pacifier? ☐ Yes ☐ No
28. Does your baby sleep on his/her back? ☐ Yes ☐ No
29. Have both parents/caregivers had the Tdap vaccine? ☐ Yes ☐ No
30. September through March visits: Have all caregivers and family members living in the home been vaccinated with the flu vaccine this season? ☐ Yes ☐ No

2 Month Questionnaire

Breast Feeding Infants:

Please answer the questions below if your infant is breast fed:

1. Are you giving vitamin D?..... ☐ Yes ☐ No
2. Breast feeding mothers, are you taking a multivitamin with iron?..... ☐ Yes ☐ No
3. Are you having any problems nursing?..... ☐ Yes ☐ No
4. Do you need help from our lactation specialists? ..... ☐ Yes ☐ No
5. Do you need help with preparations to return to work?..... ☐ Yes ☐ No

Screening questions for Tuberculosis:

1. Do you have a family member with TB or any contact with someone who has TB? ..... ☐ Yes ☐ No
2. Do any family members have a positive TB test? ..... ☐ Yes ☐ No
3. Was your child or any family member born in a high risk country (any country other than the US, Canada, Australia, New Zealand, or Western Europe)? ..... ☐ Yes ☐ No
4. Has your child or a family member traveled to a high risk country and had contact with resident populations for over 1 week? ..... ☐ Yes ☐ No
5. Has your child ever drank unpasteurized milk? ..... ☐ Yes ☐ No

Synagis Screening: (Immunization against RSV recommended by the AAP). Mark "yes" if any apply:

1. Your infant is less than 12 months old with chronic lung or congenital heart disease ..... ☐ Yes ☐ No
2. Your infant was a preemie of 28 weeks or less and is less than 12 months old ..... ☐ Yes ☐ No
3. Your infant is less than 2 years old and has chronic lung disease needing oxygen, Albuterol, diuretics or chronic steroid use in the last 6 months ..... ☐ Yes ☐ No
4. Your infant is less than 12 months old and has a congenital airway abnormality or neuromuscular disorder ..... ☐ Yes ☐ No
5. Your infant is less than 12 months old and has Cystic Fibrosis with nutritional compromise ..... ☐ Yes ☐ No
6. Your infant is under 2 years old and is profoundly immunocompromised or is undergoing a heart transplant ..... ☐ Yes ☐ No

Name and Ages of Brothers_____

Sisters _____

Patient lives with: Mom _____ Dad _____ Both Together _____ Both Separately _____

Do you have any concerns you wish to discuss? ..... ☐ Yes ☐ No

_____

_____

_____

_____

_____

_____

Edinburgh Postnatal Depression Scale[1] (EPDS)

Patient's Name: _____ Patient's Date of Birth: _____

Your Name: _____ Address: _____

Your DOB: _____ _____

Phone: _____

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 closes 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
☐ No, not very often
☐ No, not at all

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

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
   - ☐ No, not at all
   - ☐ Hardly ever
   - ☐ Yes, sometimes
   - ☐ Yes, very often

*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 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/Reviewedby:_____ Date:_____

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786