

# 1 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?.....  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 in bed?.....  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. Look at your face or the ceiling fan or lights?.....  Yes  No
16. Startle at loud noises? .....  Yes  No
17. Lift his/her head off your shoulder when held upright?.....  Yes  No
18. Move all extremities equally well?.....  Yes  No
19. Bottle fed infants: Is your child getting over 30 ounces per day?.....  Yes  No

### *Please answer the following:*

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

1 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
- 6. Will your baby take a bottle? .....  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

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## Edinburgh Postnatal Depression Scale<sup>1</sup> (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 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

\*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

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

\*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

\*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

\*8. I have felt sad or miserable

- Yes, most of the time
- Yes, quite often
- Not very often
- No, not at all

\*4. I have been anxious or worried for no good reason

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

\*9. I have been so unhappy that I have been crying

- Yes, most of the time
- Yes, quite often
- Only occasionally
- No, never

\*5. I have felt scared or panicky for no very good reason

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

\*10. The thought of harming myself has occurred to me

- Yes, quite often
- Sometimes
- Hardly ever
- Never

Administered/Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

<sup>1</sup>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