

4 Month Questionnaire

Patient's Name: _____

Personal/Social History

Are you concerned about your baby's...

1. Excessive spitting, vomiting, or back arching with feedings? Yes No
2. Bowel Movements: Does your baby have stool that is pale, gray, blood streaked or less than once every 5 days? Yes No
3. Congestion or wheezing during or after feedings? Yes No
4. Skin color or rashes (circle one)? Yes No
5. Crying more than 3 hours a day? Yes No
6. Overall development? Yes No
7. Sleep habits? Yes No

Answer the following:

8. Is your child exposed to tobacco smoke? Yes No
9. Have you been depressed or crying lately? Yes No
10. Were there any problems with your child's first set of immunizations? Yes No
11. Does your baby co-sleep with you? Yes No
12. 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...

13. Smile when you approach him/her? Yes No
14. Coo, babble, laugh, and squeal? Yes No
15. Turn his/her head toward the direction of sound? Yes No
16. Move all extremities equally well? Yes No
17. Roll over (front to back) Yes No
18. Try to bat at objects? Yes No
19. Bear weight on both legs? Yes No

Answer the following:

20. Do you have smoke alarms? _____ Carbon monoxide detectors? _____
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
28. Bottle fed infants: Is your child getting over 30 ounces per day? Yes No

4 Month Questionnaire

Breast Feeding Infants:

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

1. Are you giving a multivitamin with iron? 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 premie 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 Scale¹ (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: _____

¹Source: 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