# blackmon pediatrics

## Welcome!

To better serve the needs of our patients and families, please take a moment to answer the questions below. Circle your answers to the questions below and fill in the blanks where needed. Thank you!

**Who has brought patient in today?** _____

### Can you describe your child's nutritional habits?

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. | Feeding: | Breast | Formula | Milk | Specify Brand: _____ | |
| 2. | Feeding Problems: | | Yes | No | Specify: _____ | |
| 3. | Taking multivitamin with iron | | Yes | No | | |
| 4. | Number of diapers per day: | | Wet _____ | Strong urine stream (males): Yes | No | Stool _____ |
| 5. | Water Source: | | City | Well | Spring | Bottle |
| 6. | Taking solids: | | Cereal | Fruits | Veggies | Meats |
| 7. | Appetite: | | Good | Variable | Picky | |
| 8. | Weaned from bottle/breast | | Yes | No | | |

### Does your child have any problems with the following?

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. | Spitting Up | Yes | No | 4. | Sleep | Yes | No |
| 2. | Excessive Crying | Yes | No | 5. | Stuffy Nose | Yes | No |
| 3. | Constipation | Yes | No | 6. | Diaper Rash | Yes | No |

### Do you have any concerns about your child's hearing or vision?

Yes No Specify: _____

### Lead Screening (please answer for ages 6 months, 9 months, 12 months, and 18 months)

| | | | |
|---|---|---|---|
| 1. | Does your child live in or regularly visit a house built before 1950? | Yes | No |
| 2. | Does your child live in or regularly visit a house built before 1978 with recent renovations? | Yes | No |
| 3. | Does your child have a sibling or playmates that have or have had lead poisoning? | Yes | No |
| 4. | Do you use folk remedies that may contain or use pottery or ceramic ware for cooking, eating, or drinking? | Yes | No |

**Has there been any foreign travel in the last 60 days or international adoption?** Yes No

**Has there been any exposure to smoking?** Yes No Who: _____

### Immunizations

| | | | |
|---|---|---|---|
| 1. | Previous reaction to immunizations | Yes | No |
| 2. | Have family members been immunized (mom, dad, sibling) | Yes | No |
| 3. | History of chickenpox in child being seen | Yes | No |
| 4. | Serious illness at home or relatives (cancer) | Yes | No |
| 5. | Allergic to eggs, gelatin, Neomycin, yeast | Yes | No |

### Please describe your social history.

| | | | |
|---|---|---|---|
| 1. | Race: _____ | 4. | Ethnicity: _____ |
| 2. | Language: _____ | 5. | # Siblings: _____ |
| 3. | Lives With: _____ | | |

**Are there any medical problems in your family history that we need to be aware of? (particularly those related to childhood)** Yes No Specify: _____

### Have there been any changes in your child's medical needs?

1. New problems or illness Yes No Specify: _____
2. Please list current medications (prescription and over-the-counter) _____

# Edinburgh Postnatal Depression Scale (EPDS)

Date:_____ Clinic Name/Number:_____

Your Age:_____ Weeks of Pregnancy/Age of Baby:_____

Since you are either pregnant or have recently had a baby, we want to know how you feel. Please place a **CHECK MARK** (✔) on the blank by the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**—*not just how you feel today.* Complete all 10 items and find your score by adding each number that appears in parentheses (#) by your checked answer. This is a screening test; not a medical diagnosis. If something doesn't seem right, *call your health care provider regardless of your score.*

*Below is an example already completed.*

I have felt happy:
Yes, all of the time ____ (0)
Yes, most of the time ✔ (1)
No, not very often ____ (2)
No, not at all ____ (3)

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

1. I have been able to laugh and see the funny side of things:
   As much as I always could ____ (0)
   Not quite so much now ____ (1)
   Definitely not so much now ____ (2)
   Not at all ____ (3)

2. I have looked forward with enjoyment to things:
   As much as I ever did ____ (0)
   Rather less than I used to ____ (1)
   Definitely less than I used to ____ (2)
   Hardly at all ____ (3)

3. I have blamed myself unnecessarily when things went wrong:
   Yes, most of the time ____ (3)
   Yes, some of the time ____ (2)
   Not very often ____ (1)
   No, never ____ (0)

4. I have been anxious or worried for no good reason:
   No, not at all ____ (0)
   Hardly ever ____ (1)
   Yes, sometimes ____ (2)
   Yes, very often ____ (3)

5. I have felt scared or panicky for no good reason:
   Yes, quite a lot ____ (3)
   Yes, sometimes ____ (2)
   No, not much ____ (1)
   No, not at all ____ (0)

6. Things have been getting to me:
   Yes, most of the time I haven't been able to cope at all ____ (3)
   Yes, sometimes I haven't been coping as well as usual ____ (2)
   No, most of the time I have coped quite well ____ (1)
   No, I have been coping as well as ever ____ (0)

7. I have been so unhappy that I have had difficulty sleeping:
   Yes, most of the time ____ (3)
   Yes, sometimes ____ (2)
   No, not very often ____ (1)
   No, not at all ____ (0)

8. I have felt sad or miserable:
   Yes, most of the time ____ (3)
   Yes, quite often ____ (2)
   Not very often ____ (1)
   No, not at all ____ (0)

9. I have been so unhappy that I have been crying:
   Yes, most of the time ____ (3)
   Yes, quite often ____ (2)
   Only occasionally ____ (1)
   No, never ____ (0)

10. The thought of harming myself has occurred to me:*
    Yes, quite often ____ (3)
    Sometimes ____ (2)
    Hardly ever ____ (1)
    Never ____ (0)

**TOTAL YOUR SCORE HERE ▶** ____

*** If you scored a 1, 2 or 3 on question 10, PLEASE CALL YOUR HEALTH CARE PROVIDER (OB/Gyn, family doctor or nurse-midwife) OR GO TO THE EMERGENCY ROOM NOW** to ensure your own safety and that of your baby.

**If your total score is 11 or more,** you could be experiencing postpartum depression (PPD) or anxiety. **PLEASE CALL YOUR HEALTH CARE PROVIDER (OB/Gyn, family doctor or nurse-midwife) now** to keep you and your baby safe.

**If your total score is 9-10,** we suggest you **repeat this test in one week or call your health care provider** (OB/Gyn, family doctor or nurse-midwife).

**If your total score is 1-8, new mothers often have mood swings** that make them cry or get angry easily. Your feelings may be normal. However, if they worsen or continue for more than a week or two, call your health care provider (OB/Gyn, family doctor or nurse-midwife). Being a mother can be a new and stressful experience. Take care of yourself by:

- ▶ Getting sleep—nap when the baby naps.
- ▶ Asking friends and family for help.
- ▶ Drinking plenty of fluids.
- ▶ Eating a good diet.
- ▶ Getting exercise, even if it's just walking outside.

**Regardless of your score, if you have concerns about depression or anxiety, please contact your health care provider.**

*Please note: The Edinburgh Postnatal Depression Scale (EPDS) is a screening tool that does not diagnose postpartum depression (PPD) or anxiety.*

*See more information on reverse.* ▶

Edinburgh Postnatal Depression Scale (EPDS). Adapted from the *British Journal of Psychiatry*, June, 1987, vol. 150 by J.L. Cox, J.M. Holden, R. Segovsky.