

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 | Yes | No | Specify: | _____ |
| 3. | Taking multivitamin with iron | Yes | 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. ►