Patient:_____ Date:_____ MRN:_____

# Bright Futures Previsit Questionnaire
# 1 Month Visit

For us to provide you and your baby with the best possible health care, we would like to know how things are going.
Please answer all of the questions. Thank you.

## What would you like to talk about today?

**Do you have any concerns, questions, or problems that you would like to discuss today?**

_____

**We are interested in answering your questions. Please check off the boxes for the topics you would like to discuss the most today.**

| | |
|---|---|
| **How You Are Feeling** | ☐ Feeling sad ☐ Using drugs ☐ Using alcohol ☐ Smoking ☐ Getting back to work or school<br>☐ Breastfeeding plans ☐ Choosing child care |
| **Your Baby and Family** | ☐ Asking for help when you need it ☐ Community services that may be able to help your family<br>☐ Violence at home/abuse |
| **Getting to Know Your Baby** | ☐ Sleep/wake schedules ☐ Where your baby sleeps ☐ How your baby sleeps<br>☐ How to keep your baby safe while sleeping ☐ Bored baby ☐ Tummy time for playtime with you<br>☐ How to calm your baby ☐ Crying too much |
| **Feeding Your Baby** | ☐ How often you should feed your baby ☐ How to know your baby is getting enough ☐ What to feed your baby<br>☐ Formula feeding ☐ Help with breastfeeding ☐ How to hold your baby while feeding<br>☐ Burping ☐ Using a pacifier ☐ Worry about your baby's weight |
| **Safety** | ☐ Car safety seats ☐ Preventing falls ☐ Choking from bracelets, necklaces, and toys with loops or strings |

## Questions About Your Baby

**Have any of your baby's relatives developed new medical problems since your last visit? If yes, please describe:** ☐ Yes ☐ No ☐ Unsure

_____

| | | | | |
|---|---|---|---|---|
| **Vision** | Do you have concerns about how your child sees? | ☐ Yes | ☐ No | ☐ Unsure |
| **Tuberculosis** | Has a family member or contact had tuberculosis or a positive tuberculin skin test? | ☐ Yes | ☐ No | ☐ Unsure |
| | Was your child born in a country at high risk for tuberculosis (countries other than the United Sates, Canada, Australia, New Zealand, and Western Europe)? | ☐ Yes | ☐ No | ☐ Unsure |
| | Has your child traveled (had contact with resident populations) for longer than 1 week to a country at high risk for tuberculosis? | ☐ Yes | ☐ No | ☐ Unsure |

**Does your child have any special health care needs?** ☐ No ☐ Yes, describe:

_____

**Other than your baby's birth, have there been any major changes in your family lately?**
☐ Move ☐ Job change ☐ Separation ☐ Divorce ☐ Death in the family ☐ Any other changes? Describe:

_____

**Over the past 2 weeks, how often have you been bothered by any of the following problems?**
1. Little interest or pleasure in doing things ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
2. Feeling down, depressed, or hopeless ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day



**Does your child live with anyone who uses tobacco or spend time in any place where people smoke?** ☐ No ☐ Yes

## Your Growing and Developing Baby

**Do you have specific concerns about your baby's development, learning, or behavior?** ☐ No ☐ Yes, describe:

_____

**Check off each of the tasks that your baby is able to do.**
☐ If upset, able to calm ☐ Recognizes parents' voices ☐ Lifts head when on tummy
☐ Follows parents with eyes ☐ Smiles

Bright Futures™ prevention and health promotion for infants, children, adolescents, and their families™

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

# Edinburgh Postnatal Depression Scale (EPDS)

Patient Label

Mother's OB or Doctor's Name:

_____

Doctor's Phone #: _____

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 ▶**

Thank you for completing this survey. Your doctor will score this survey and discuss the results with you.

Verbal consent to contact above mentioned MD witnessed by:

_____

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.