Patient Name:

Date of Birth:

Well Baby Check: 4 month visit questionnaire

Interval History:

Has your baby had any major illnesses or doctor visits since last seen? No ☐ Yes ☐

Has your baby had any reactions to vaccinations given in the past? No ☐ Yes ☐

Development: Can your baby (check all that apply) -

- ☐ follow your face/object as it moves side to side?
- ☐ turn toward voices or sounds?
- ☐ lift their head and chest when lying on his/her tummy?
- ☐ squeal, laugh and initiate interactions?
- ☐ reach for and grasp objects?
- ☐ bring their hands together?
- ☐ have a steady head when sitting upright?
- ☐ roll over?

Who provides daytime care for your child? _____

Nutrition/Elimination:

For Breastfeeding: _____ minutes per side every _____ hours

For bottle feeding: _____ ounces every _____ hours of [breastmilk] ☐ [formula] ☐ _____

Do you give your baby a bottle of anything other than formula or breast milk? No ☐ Yes ☐

Have you started any solid foods for your baby? No ☐ Yes ☐

Do you have any concerns about your baby's feeding? No ☐ Yes ☐

Does your baby have daily poops with a soft/loose consistency? Yes ☐ No ☐

Baby's medications/vitamins/supplements: _____

Mother's medications/vitamins/supplements if giving breastmilk: _____

Sleep:

What is the longest time your baby sleeps at night without feeding? _____ hours

Do you always put your baby to sleep on her/his back? Yes ☐ No ☐

Where does your baby sleep? _____

Staying Healthy/Safety:

Does your baby get any screen time? No ☐ Yes ☐

Does your home have a working smoke detector? Yes ☐ No ☐

Do you always stay with your baby when she/he is in the bathtub? Yes ☐ No ☐

Do you always place your baby in a rear-facing car seat in the back seat? Yes ☐ No ☐

Is your car seat the right one for the age and size of your baby? Yes ☐ No ☐

Does your baby spend time with anyone who smokes or vapes? No ☐ Yes ☐

Please list any new major family medical issues:

_____

Patient Name:

Date of Birth:

Who lives in the home with your child?

_____

What international travel has your child had since their last well check? (where and how long)

_____

What plans are there for international travel with your child in the next 12 months? (where and how long)

_____

What concerns would you like to discuss today?

_____

Stanford Children's Health | Lucile Packard Children's Hospital Stanford
Lucile Salter Packard Children's Hospital
STANFORD UNIVERSITY MEDICAL CENTER ● 725 Welch Road, Palo Alto, CA 94304

Patient Name:

Date of Birth:

Questionnaire ● Edinburg Postnatal Dep Scale

Edinburgh Postnatal Depression Scale1 (EPDS)

Mother's Name: _____ Baby's Name: _____

Today's Date: _____ Baby's Date of Birth: _____

As you 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.

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

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

*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

4. I have been anxious or worried for no good reason
   - ☐ No, not at all
   - ☐ Hardly ever
   - ☐ Yes, sometimes
   - ☐ Yes, very often

*5. I have felt scared or panicky for no very good reason
   - ☐ Yes, quite a lot
   - ☐ Yes, sometimes
   - ☐ No, not much
   - ☐ No, 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

*7. I have been so unhappy that I have had difficulty sleeping
   - ☐ Yes, most of the time
   - ☐ Yes, sometimes
   - ☐ Not very often
   - ☐ No, not at allwent

*8. I have felt sad or miserable
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Not very often
   - ☐ No, not at all

* 9. I have been so unhappy that I have been crying
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Only occasionally
   - ☐ No, never

*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 Endinburgh Postnatal Depression Scale. British Journal of Psychiatry 150:782-786.
2Source: K.L. Wisner, B.L. Parry, C.M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002.

Stanford Children's Health | Lucile Packard Children's Hospital Stanford

Patient Name:

Date of Birth:

Questionnaire ● Edinburg Postnatal Dep Scale

Maternal Stress Test

Having a baby can be a challenging adjustment and can sometimes bring up difficult feelings. To help us understand how you are feeling, please complete the survey on the back of this sheet. Please circle the number next to the statement that comes closest to how you have felt in the past seven days, not just how you are feeling today.

Many women who are pregnant or who have recently had a baby struggle with feeling worried or overwhelmed. For those who score 10 or higher on this survey, do we have your permission for a counselor to call and check in with you about how you are feeling? You may also contact a counselor directly by calling Maternal Outreach Mood Services at El Camino Hospital at (650) 988-8468.

☐ Yes, a counselor may contact me about the results of this test.

☐ No, I would prefer not to have a counselor contact me.

_____ _____

Signature Date

Best phone number to reach me: _____

May a message be left on the voicemail? ☐ Yes ☐ No

*** Please turn this sheet over and complete the survey and return it to the doctor ***

Provider use:

Date: _____ Provider name: _____

Action taken: _____ Faxed to Maternal Outreach Mood Services, fax (650) 448-1417

_____ Results called in to Maternal Outreach Mood Services (650) 988-8468

_____ No action required

_____ Other action taken: _____

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