



Patient Name:

Date of Birth:

Well Baby Check: 6 month visit questionnaire

Interval History:

- Has your baby had any major illnesses or doctor visits since last seen here? No Yes
Has your baby had any reactions to vaccinations in the past? No Yes

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

- pass objects from one hand to the other? babble consonants (“ba”, “ga”, “ma”)?
- grasp objects and put them near his/her mouth? sit with some support?
- focus on and see small objects? roll over?
- move their eyes together without crossing? lift their head when lifted from the car seat?

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] _____

Does your baby drink anything other than formula, breast milk or water? No Yes

Have you started feeding your baby a variety of solid foods? Yes No

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: _____

Dental Health:

Does your child sleep with a bottle or breastfeed throughout the night? No Yes

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

Can your baby self-soothe? 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

Is your water temperature set to less than 120 degrees? Yes No N/A

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

Do you have safety guards on upper floor windows and gates for stairs? Yes No N/A

Does your home have cleaning supplies/medicines/matches locked away? Yes No

Is the Poison Control Center number (800-222-1222) posted by/in your phone? Yes No

Do you use sun protection on your child when outdoors? Yes No

Is your car seat appropriately sized, rear-facing, and in the back seat? Yes No

Are all guns stored in a gun safe or locked with ammunition separate from gun? Yes No N/A

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

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Questionnaire • Well Baby Check 6 Month

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Please list any new major family medical issues:

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?



Patient Name: _____

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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:

- | | |
|---|--|
| <p>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</p> <p>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</p> <p>*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</p> <p>4. I have been anxious or worried for no good reason
No, not at all
Hardly ever
Yes, sometimes
Yes, very often</p> <p>*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</p> | <p>*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</p> <p>*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 all</p> <p>*8. I have felt sad or miserable
Yes, most of the time
Yes, quite often
Not very often
No, not at all</p> <p>*9. I have been so unhappy that I have been crying
Yes, most of the time
Yes, quite often
Only occasionally
No, never</p> <p>*10. The thought of harming myself has occurred to me
Yes, quite often
Sometimes
Hardly ever
Never</p> |
|---|--|

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.

2Source: K.L. Wisner, B.L. Parry, C.M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002.



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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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