Appt Date_____ 1 month Check Up

Patient Name _____DOB_____

Name of person filling out form _____Phone number_____

Nutrition:

Is your baby breast or bottle fed? (circle all that apply) Formula Breast Milk at the Breast Pumped Breast Milk

If your baby gets formula, which formula are you using?_____

When fed from a bottle, how many ounces will your baby take per feeding? _____

When feeding at the breast, how many minutes will the baby nurse (on both sides combined)? _____

How many total feedings in 24 hours?_____

Do you give Vitamin drops? YES NO If so, what kind_____

Bowel/Bladder:

The baby has _____ wet diapers in 24 hours. The baby has _____stools in 24 hours.

Sleep:

Does your baby sleep on his/her back?_____

Where does your baby sleep?_____

How many naps does your baby take during the day?_____ How long are the naps?_____

How many hours does your baby sleep between nighttime feedings?_____

Social hx:

Does your child attend daycare, preschool, or stay at home?_____

Development Please check the following milestones that you notice your child accomplishing:

___Lifts head when lying on his/her belly

___Responds/startles to a sound

___Follows an object from right to left with his/her eyes until the mid-line

___Moves right and left sides equally (arms and legs)

___Looks at your face

___Holds hands mostly tightly fisted

Advice and Guidance for Parents: *(please check off as you read)*

___Set hot water thermostat to <120 degrees

___ Nutrition: no water, no juice until 4 months, only formula or breast milk

___Smoke Exposure: Minimize your child's exposure to cigarette smoke

___Does anyone smoke inside your home, including the basement or garage? Y___ N____; If yes is he/she interested in quitting? Y____ N____

___Does anyone caring for your child smoke in the house, car, basement, garage, or outside? Y___ N___; If yes, is he/she interested in quitting? Y___ N___

___Sleep position: back only

___Sleep Routine: be consistent to develop a regular sleep/wake pattern

___Colic/crying: expect 2 to 3 hours of crying per day, usually worse in the evenings

___Start with "tummy time" 3 to 5 times per day

___Sleep duration: Most infants sleep 2-4 hours between feedings

(for podcasts on Sleep, go to www.shotshurtless.com)

Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____ _____

Baby's Date of Birth: _____ Phone: _____

As you are pregnant or 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.

Here is an example, already completed.

I have felt happy:

- ☐ Yes, all the time
- ☒ Yes, most of the time
- ☐ No, not very often
- ☐ No, not at all

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

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 copied 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 all

*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 _____

[1]Source: 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.