

Appt Date _____

2 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:

- ___ Smiles spontaneously to parents
- ___ Vocalizes and responds to sound from parents
- ___ Lifts head up to 45 degree angle when lying on his/her belly
- ___ Follows an object from right to left with his/her eyes past midline
- ___ Moves right and left sides equally (arms and legs)
- ___ Briefly holds a rattle

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: *Put your baby down to sleep while he/she is still awake*
- ___ Colic/crying: expect 2 to 3 hours of crying per day
- ___ Continue with "tummy time" 3 to 5 times per day
- ___ Sleep duration: Most sleep 4-6 hours between nighttime feedings and take 3 naps
(for podcasts on Sleep, go to www.shotshurtless.com)

Edinburgh Postnatal Depression Scale¹ (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 This would mean: "I have felt happy most of the time" during the past week.
- ☐ No, not very often Please complete the other questions in the same way.
- ☐ No, not at all

In the past 7 days:

- | | |
|--|--|
| <p>1. I have been able to laugh and see the funny side of things</p> <ul style="list-style-type: none"><input type="checkbox"/> As much as I always could<input type="checkbox"/> Not quite so much now<input type="checkbox"/> Definitely not so much now<input type="checkbox"/> Not at all <p>2. I have looked forward with enjoyment to things</p> <ul style="list-style-type: none"><input type="checkbox"/> As much as I ever did<input type="checkbox"/> Rather less than I used to<input type="checkbox"/> Definitely less than I used to<input type="checkbox"/> Hardly at all <p>*3. I have blamed myself unnecessarily when things went wrong</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes, most of the time<input type="checkbox"/> Yes, some of the time<input type="checkbox"/> Not very often<input type="checkbox"/> No, never <p>4. I have been anxious or worried for no good reason</p> <ul style="list-style-type: none"><input type="checkbox"/> No, not at all<input type="checkbox"/> Hardly ever<input type="checkbox"/> Yes, sometimes<input type="checkbox"/> Yes, very often <p>*5. I have felt scared or panicky for no very good reason</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes, quite a lot<input type="checkbox"/> Yes, sometimes<input type="checkbox"/> No, not much<input type="checkbox"/> No, not at all | <p>*6. Things have been getting on top of me</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes, most of the time I haven't been able to cope at all<input type="checkbox"/> Yes, sometimes I haven't been coping as well as usual<input type="checkbox"/> No, most of the time I have coped quite well<input type="checkbox"/> No, I have been coping as well as ever <p>*7. I have been so unhappy that I have had difficulty sleeping</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes, most of the time<input type="checkbox"/> Yes, sometimes<input type="checkbox"/> Not very often<input type="checkbox"/> No, not at all <p>*8. I have felt sad or miserable</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes, most of the time<input type="checkbox"/> Yes, quite often<input type="checkbox"/> Not very often<input type="checkbox"/> No, not at all <p>*9. I have been so unhappy that I have been crying</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes, most of the time<input type="checkbox"/> Yes, quite often<input type="checkbox"/> Only occasionally<input type="checkbox"/> No, never <p>*10. The thought of harming myself has occurred to me</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes, quite often<input type="checkbox"/> Sometimes<input type="checkbox"/> Hardly ever<input type="checkbox"/> 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 Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.

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