COOKEVILLE PEDIATRIC ASSOCIATES, P.C.

2-4 Week Checkup Questionnaire

PATIENT:_____ GUARANTOR:_____
DOB:___/___/___ DATE: ___/___/___
Source of information: (check one)
Mother ____
Father ____
Other (specify)_____

Which of the following do you have: (check one)
City water ____ Well water ____ Bottled water ____ Spring water ____

Do you breast feed? Yes ____ No ____
If yes, how many minutes per feeding? _____
How many times per day? _____
Any difficulty breastfeeding? Yes ____ No ____
If yes, explain: _____
_____

Bottle-feeding? Yes ____ No ____
If yes, which formula do you use? _____
How many ounces per feeding? _____
How many hours between feedings? _____
Any difficulty bottle-feeding? Yes ____ No ____
If yes, explain: _____
_____

WIC services: Yes ____ No ____

Bowel movement frequency: _____ times per day
Number of wet diapers per day: _____

PROBLEMS: Constipation Yes ____ No ____
Sleep problems Yes ____ No ____
Spitting up Yes ____ No ____
Excessive crying Yes ____ No ____

DEVELOPMENTAL: Responds to sounds Yes ____ No ____
Fixes on faces Yes ____ No ____
Extremeties move equally Yes ____ No ____
Lifts chin off surface Yes ____ No ____

Parent Questionnaire

To help our office better serve our families with children under the age of two years, in relation to the winter respiratory infection with RSV (respiratory syncytial virus), please complete this questionnaire.

Child's Name:_____

Date of Birth:_____

1. Was your child born more than four weeks early (prematurely)?
   - ☐ Yes (How many weeks?) _____
   - ☐ No

2. Was your child in the neonatal intensive care unit (NICU) after birth?
   - ☐ Yes (How many days?)_____
   - ☐ No

3. Has your child ever been re-hospitalized?
   - ☐ Yes (If yes, please explain)_____
   - ☐ No

4. Has your child ever had any respiratory or breathing difficulties?
   - ☐ Yes (if yes, please explain)_____
   - ☐ No

5. Does your child have an immune deficiency?
   - ☐ Yes (If yes, please explain)_____
   - ☐ No

7. Please check any of the situations listed below that may pertain to your child.
   - ☐ My child is around other children for more than 4hours per week.
   - ☐ My child attends day care, either in the home, a center, gym, or place of worship
   - ☐ My child lives with siblings or other children.
   - ☐ My child is exposed to tobacco smoke, wood burning stoves or kerosene heaters.
   - ☐ My child lives over 30miles from the nearest hospital.

Signature:_____ Date:_____

Sample Signature Page for New Mothers
Re: Edinburgh Postnatal Depression Scale

Congratulations on your new baby!

We are excited to be a part of this important time in your life! Our job is to make sure your baby is getting the best health care possible and to help you adjust to the changes the new baby rings to your life.

We'd like to take a few minutes to ask about how you are adjusting during these first few weeks. Please take a moment to answer the brief questionnaire found on the following page. Your answers should reflect your feelings over the past 7 days.

We would like your permission to share your responses with your obstetrician. Please indicate your physician's name below and sign where indicated.

Obstetrician's Name _____ Phone # _____

Your Name _____

Your Signature _____ Date _____

EPDS

Name: _____

Date: _____ Baby's Age: _____

As you have recently had a baby, we would like to know how you are feeling. Please mark 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.

I have felt happy:

- ☐ Yes, all the time
- ■ Yes, most of the time
- ☐ No, not very often
- ☐ 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.

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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 not 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 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

_____

EDINBURGH POSTNATAL DEPRESSION SCALE (EPDS)
J. L. Cox, J.M. Holden, R. Sagovsky
From: *British Journal of Psychiatry* (1987), 150, 782-786.

6/11/08

Bright Futures Parent Handout
1 Month Visit

Here are some suggestions from Bright Futures experts that may be of value to your family.

PARENTAL WELL-BEING

How You Are Feeling

- Taking care of yourself gives you the energy to care for your baby. Remember to go for your postpartum checkup.
- Call for help if you feel sad or blue, or very tired for more than a few days.
- Know that returning to work or school is hard for many parents.
- Find safe, loving child care for your baby. You can ask us for help.
- If you plan to go back to work or school, start thinking about how you can keep breastfeeding.

INFANT ADJUSTMENT

Getting to Know Your Baby

- Have simple routines each day for bathing, feeding, sleeping, and playing.
- Put your baby to sleep on his back.
  - In a crib, in your room, not in your bed.
  - In a crib that meets current safety standards, with no drop-side rail and slats no more than 2 3/8 inches apart. Find more information on the Consumer Product Safety Commission Web site at www.cpsc.gov.
  - If your crib has a drop-side rail, keep it up and locked at all times. Contact the crib company to see if there is a device to keep the drop-side rail from falling down.
  - Keep soft objects and loose bedding such as comforters, pillows, bumper pads, and toys out of the crib.
  - Give your baby a pacifier if he wants it.
- Hold and cuddle your baby often.
  - Tummy time—put your baby on his tummy when awake and you are there to watch.
- Crying is normal and may increase when your baby is 6–8 weeks old.
- When your baby is crying, comfort him by talking, patting, stroking, and rocking.
- *Never shake your baby.*
- If you feel upset, put your baby in a safe place; call for help.

SAFETY

Safety

- Use a rear-facing car safety seat in all vehicles.
- Never put your baby in the front seat of a vehicle with a passenger air bag.
- Always wear your seat belt and never drive after using alcohol or drugs.
- Keep your car and home smoke-free.
- Keep hanging cords or strings away from and necklaces and bracelets off of your baby.
- Keep a hand on your baby when changing clothes or the diaper.

FAMILY ADJUSTMENT

Your Baby and Family

- Plan with your partner, friends, and family to have time for yourself.
- Take time with your partner too.
- Let us know if you are having any problems and cannot make ends meet. There are resources in our community that can help you.
- Join a new parents group or call us for help to connect to others if you feel alone and lonely.
- Call for help if you are ever hit or hurt by someone and if you and your baby are not safe at home.
- Prepare for an emergency/illness.
  - Keep a first-aid kit in your home.
  - Learn infant CPR.
  - Have a list of emergency phone numbers.
  - Know how to take your baby's temperature rectally. Call us if it is 100.4°F (38.0°C) or higher.
- Wash your hands often to help your baby stay healthy.

Feeding Your Baby

- Feed your baby only breast milk or iron-fortified formula in the first 4–6 months.

FEEDING ROUTINES

- Pat, rock, undress, or change the diaper to wake your baby to feed.
- Feed your baby when you see signs of hunger.
  - Putting hand to mouth
  - Sucking, rooting, and fussing
- End feeding when you see signs your baby is full.
  - Turning away
  - Closing the mouth
  - Relaxed arms and hands
- Breastfeed or bottle-feed 8–12 times per day.
- Burp your baby during natural feeding breaks.
- Having 5–8 wet diapers and 3–4 stools each day shows your baby is eating well.

If Breastfeeding

- Continue to take your prenatal vitamins.
- When breastfeeding is going well (usually at 4–6 weeks), you can offer your baby a bottle or pacifier.

If Formula Feeding

- Always prepare, heat, and store formula safely. If you need help, ask us.
- Feed your baby 2 oz every 2–3 hours. If your baby is still hungry, you can feed more.
- Hold your baby so you can look at each other.
- Do not prop the bottle.

What to Expect at Your Baby's 2 Month Visit

We will talk about

- Taking care of yourself and your family
- Sleep and crib safety
- Keeping your home safe for your baby
- Getting back to work or school and finding child care
- Feeding your baby

Poison Help: 1-800-222-1222

Child safety seat inspection:
1-866-SEATCHECK; seatcheck.org

Bright Futures.

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™