



ABC Pediatrics

Four Month Pre-visit Questionnaire

Patient Name _____

Date _____

Bathes: (Daily) (Every other day)

Feeding Routine (circle one): Breast feeding Bottle Feeding Both

Formula: _____ Ounces per feeding? _____ Every how many hours? _____

of stools Daily _____ # of voids Daily _____ # of hours sleeping at ONE time _____

Is your child drinking anything else other than breast milk or iron-fortified formula? **YES NO**

Current daycare: _____

Over the past 2 weeks have you felt depressed, hopeless, or felt like you've lost interest in doing things? _____

Have there been any major changes in your family recently other than your baby's birth?


Developmental Milestones (circle all that apply)

- | | | | |
|-------------------------------------------------------------------------|---------------------------------------------------------|--------------------------------------------------------|---------------------------------------------------------------------------|
| <input type="checkbox"/> Turns to voice | <input type="checkbox"/> Vocalizes with extended cooing | <input type="checkbox"/> Laughs | <input type="checkbox"/> Rolls over from prone to supine. (front to back) |
| <input type="checkbox"/> Supports on elbows and wrists in prone (front) | <input type="checkbox"/> Keeps hands unfisted | <input type="checkbox"/> Plays with fingers in midline | <input type="checkbox"/> Grasps objects |

Any other questions or concerns you would like to discuss?

For Office Use Only

Weight: _____ Height: _____ HC: _____ Temp: _____

Please Turn Over 

Edinburgh Postnatal Depression Scale (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:

1. I have been able to laugh and see the funny side of things

- Yes, all the time
- Yes, most of the time
- No, not very often
- No, 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've coped quite well
- No, I have been coping as well as ever

7. I have been so unhappy that I've 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've 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