



# ABC Pediatrics

## Six Month Pre-visit Questionnaire

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

**Bathes: (Daily) (Every other day)**

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

Formula: \_\_\_\_\_ Ounces per feeding? \_\_\_\_\_ Every how many hours? \_\_\_\_\_

Solids: Cereals \_\_\_\_\_ Rice \_\_\_\_\_ Stage \_\_\_\_\_ baby foods Others \_\_\_\_\_

# of stools Daily \_\_\_\_\_ # of voids Daily \_\_\_\_\_

Type of water (bottled/well/city): \_\_\_\_\_ # of hours sleeping at ONE time \_\_\_\_\_

Current Daycare: \_\_\_\_\_

### Developmental Milestones (check all that apply)

#### Any other questions or concerns you would like to discuss?

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Babbles                      | <input type="checkbox"/> Pats or smiles at reflection      | <input type="checkbox"/> Begins to turn when name is called | <input type="checkbox"/> Rolls over supine to prone (back to front) |
| <input type="checkbox"/> Sits briefly without support | <input type="checkbox"/> Reaches for objects and transfers | <input type="checkbox"/> Rakes at small objects             | <input type="checkbox"/> Bangs small objects on surfaces.           |

TB Screen	Has a family member or contact been diagnosed with TB?	YES	NO
	Was your child born in a country at high risk for TB?	YES	NO
	Has your child traveled to a country at high risk for TB?	YES	NO
Lead Risk	Does your child have a sibling or playmate that has had lead poisoning?	YES	NO
	Does your child live in or regularly visit a home built before 1978 that being renovated?	YES	NO
	Does your child live in or regularly visit a house or childcare facility built before 1950?	YES	NO

\*\*\*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