Child Name: _____

Bright Futures Previsit Questionnaire
2 to 5 Day (First Week) Visit

For us to provide you and your baby with the best possible health care, we would like to know how things are going.
Please answer all of the questions. Thank you.

What would you like to talk about today?

Do you have any concerns, questions, or problems that you would like to discuss today?

_____

_____

_____

We are interested in answering your questions. Please check off the boxes for the topics you would like to discuss the most today.

How You Are Feeling	☐ Your health ☐ Feeling sad ☐ Family stress ☐ Unwanted advice ☐ Starting a daily routine
Getting Used to Your Baby	☐ How you are doing with your baby ☐ Calming your baby ☐ Crib safety ☐ Where your baby sleeps ☐ How your baby sleeps ☐ Placing baby on back to sleep
Feeding Your Baby	☐ Gaining weight ☐ How your baby shows if he/she is hungry or full ☐ Drinking enough ☐ Jaundice (skin is yellow) ☐ Burping ☐ Breastfeeding ☐ Formula
Safety	☐ Car safety seat ☐ Cigarette smoke ☐ Water heater temperature
Baby Care	☐ When to call the doctor's office ☐ Taking your baby's temperature ☐ Not getting sick ☐ Hand washing ☐ Emergency situations ☐ Leaving the house ☐ Skin care ☐ Sunburns

Questions About Your Baby

Have any of your baby's relatives developed new medical problems since your last visit? If yes, please describe: ☐ Yes ☐ No ☐ Unsure

_____

_____

Vision	Do you have concerns about how your child sees?	☐ Yes	☐ No	☐ Unsure

Does your child have any special health care needs? ☐ No ☐ Yes, describe:

_____

_____

Other than your baby's birth, have there been any major changes in your family lately?
☐ Move ☐ Job change ☐ Separation ☐ Divorce ☐ Death in the family ☐ Any other changes? Describe:

_____

_____

Over the past 2 weeks, how often have you been bothered by any of the following problems?
1. Little interest or pleasure in doing things ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
2. Feeling down, depressed, or hopeless ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Does your child live with anyone who uses tobacco or spend time in any place where people smoke? ☐ No ☐ Yes

Your Growing and Developing Baby

Do you have specific concerns about how your baby is growing, learning, or acting? ☐ No ☐ Yes, describe:

_____

_____

Check off each of the tasks that your baby is able to do.

☐ Eats well
☐ Turns and calms to your voice
☐ Follows your face
☐ Can suck, swallow, and breathe easily

Bright Futures™
prevention and health promotion for infants, children, adolescents, and their families™

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: _____

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 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

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 .

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199