1 Month Forms

Patient Name: _____

Bright Futures Previsit Questionnaire
1 Month 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	☐ Feeling sad ☐ Using drugs ☐ Using alcohol ☐ Smoking ☐ Getting back to work or school ☐ Breastfeeding plans ☐ Choosing child care
Your Baby and Family	☐ Asking for help when you need it ☐ Community services that may be able to help your family ☐ Violence at home/abuse
Getting to Know Your Baby	☐ Sleep/wake schedules ☐ Where your baby sleeps ☐ How your baby sleeps ☐ How to keep your baby safe while sleeping ☐ Bored baby ☐ Tummy time for playtime with you ☐ How to calm your baby ☐ Crying too much
Feeding Your Baby	☐ How often you should feed your baby ☐ How to know your baby is getting enough ☐ What to feed your baby ☐ Formula feeding ☐ Help with breastfeeding ☐ How to hold your baby while feeding ☐ Burping ☐ Using a pacifier ☐ Worry about your baby's weight
Safety	☐ Car safety seats ☐ Preventing falls ☐ Choking from bracelets, necklaces, and toys with loops or strings

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
Tuberculosis	Has a family member or contact had tuberculosis or a positive tuberculin skin test?	☐ Yes	☐ No	☐ Unsure
	Was your child born in a country at high risk for tuberculosis (countries other than the United Sates, Canada, Australia, New Zealand, and Western Europe)?	☐ Yes	☐ No	☐ Unsure
	Has your child traveled (had contact with resident populations) for longer than 1 week to a country at high risk for tuberculosis?	☐ 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 your baby's development, learning, or behavior? ☐ No ☐ Yes, describe:

_____

Check off each of the tasks that your baby is able to do.
☐ If upset, able to calm ☐ Recognizes parents' voices ☐ Lifts head when on tummy
☐ Follows parents with eyes ☐ Smiles

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

Edinburgh Postnatal Depression Scale[1] (EPDS)

Mother's Name: _____ Baby's Name:_____

Mother's Date of Birth: _____ Baby's Date of Birth: _____

Phone: _____ OBGYN:_____

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
   - □ 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 _____