



Patient Name:

Date of Birth:

## Well Baby Check: 6 month visit questionnaire

### Interval History:

Has your baby had any major illnesses or doctor visits since last seen here? No Yes

Has your baby had any reactions to vaccinations in the past? No Yes

### Development: Can your baby (check all that apply) -

\_ pass objects from one hand to the other?

\_ babble consonants ("ba", "ga", "ma")?

\_ grasp objects and put them near his/her mouth?

\_ sit with some support?

\_ focus on and see small objects?

\_ roll over?

\_ move their eyes together without crossing?

\_ lift their head when lifted from the car seat?

Who provides daytime care for your child? \_\_\_\_\_

### Nutrition/Elimination:

For Breastfeeding: \_\_\_\_\_ minutes per side every \_\_\_\_\_ hours

For bottle feeding: \_\_\_\_\_ ounces every \_\_\_\_\_ hours of [breastmilk] [formula \_\_\_\_\_]

Does your baby drink anything other than formula, breast milk or water? No Yes

Have you started feeding your baby a variety of solid foods? Yes No

Does your baby have daily poops with a soft/loose consistency? Yes No

Baby's medications/vitamins/supplements: \_\_\_\_\_

Mother's medications/vitamins/supplements if giving breastmilk: \_\_\_\_\_

### Dental Health:

Does your child sleep with a bottle or breastfeed throughout the night? No Yes

### Sleep:

What is the longest time your baby sleeps at night without feeding? \_\_\_\_\_ hours

Do you always put your baby to sleep on her/his back? Yes No

Can your baby self-soothe? Yes No

Where does your baby sleep? \_\_\_\_\_

### Staying Healthy/Safety:

Does your baby get any screen time? No Yes

Does your home have a working smoke detector? Yes No

Is your water temperature set to less than 120 degrees? Yes No N/A

Do you always stay with your baby when she/he is in the bathtub? Yes No

Do you have safety guards on upper floor windows and gates for stairs? Yes No N/A

Does your home have cleaning supplies/medicines/matches locked away? Yes No

Is the Poison Control Center number (800-222-1222) posted by/in your phone? Yes No

Do you use sun protection on your child when outdoors? Yes No

Is your car seat appropriately sized, rear-facing, and in the back seat? Yes No

Are all guns stored in a gun safe or locked with ammunition separate from gun? Yes No N/A

Does your baby spend time with anyone who smokes or vapes? No Yes



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Questionnaire • Well Baby Check 6 Month

Page 2 of 2

Please list any new major family medical issues:

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Who lives in the home with your child?

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What international travel has your child had since their last well check? (where and how long)

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What plans are there for international travel with your child in the next 12 months? (where and how long)

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What concerns would you like to discuss today?

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Questionnaire • Edinburg Postnatal Dep Scale

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

### Edinburgh Postnatal Depression Scale1 (EPDS)

Mother's Name: \_\_\_\_\_

Baby's Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Baby's Date of Birth: \_\_\_\_\_

As you 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.

In the past 7 days:

- |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
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| <p>1. I have been able to laugh and see the funny side of things<br/>           As much as I always could<br/>           Not quite so much now<br/>           Definitely not so much now<br/>           Not at all</p> <p>2. I have looked forward with enjoyment to things<br/>           As much as I ever did<br/>           Rather less than I used to<br/>           Definitely less than I used to<br/>           Hardly at all</p> <p>*3. I have blamed myself unnecessarily when things went wrong<br/>           Yes, most of the time<br/>           Yes, some of the time<br/>           Not very often<br/>           No, never</p> <p>4. I have been anxious or worried for no good reason<br/>           No, not at all<br/>           Hardly ever<br/>           Yes, sometimes<br/>           Yes, very often</p> <p>*5. I have felt scared or panicky for no very good reason<br/>           Yes, quite a lot<br/>           Yes, sometimes<br/>           No, not much<br/>           No, not at all</p> | <p>*6. Things have been getting on top of me<br/>           Yes, most of the time I haven't been able to cope at all<br/>           Yes, sometimes I haven't been coping as well as usual<br/>           No, most of the time I have coped quite well<br/>           No, I have been coping as well as ever</p> <p>*7. I have been so unhappy that I have had difficulty sleeping<br/>           Yes, most of the time<br/>           Yes, sometimes<br/>           Not very often<br/>           No, not at all</p> <p>*8. I have felt sad or miserable<br/>           Yes, most of the time<br/>           Yes, quite often<br/>           Not very often<br/>           No, not at all</p> <p>*9. I have been so unhappy that I have been crying<br/>           Yes, most of the time<br/>           Yes, quite often<br/>           Only occasionally<br/>           No, never</p> <p>*10. The thought of harming myself has occurred to me<br/>           Yes, quite often<br/>           Sometimes<br/>           Hardly ever<br/>           Never</p> |
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Administered/Reviewed by \_\_\_\_\_

Date \_\_\_\_\_

1Source: 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.

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

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Questionnaire • Edinburg Postnatal Dep Scale

## Maternal Stress Test

Having a baby can be a challenging adjustment and can sometimes bring up difficult feelings. To help us understand how you are feeling, please complete the survey on the back of this sheet. Please circle the number next to the statement that comes closest to how you have felt in the past seven days, not just how you are feeling today.

Many women who are pregnant or who have recently had a baby struggle with feeling worried or overwhelmed. For those who score 10 or higher on this survey, do we have your permission for a counselor to call and check in with you about how you are feeling? You may also contact a counselor directly by calling Maternal Outreach Mood Services at El Camino Hospital at (650) 988-8468.

Yes, a counselor may contact me about the results of this test.

No, I would prefer not to have a counselor contact me.

\_\_\_\_\_  
Signature\_\_\_\_\_  
Date

Best phone number to reach me: \_\_\_\_\_

May a message be left on the voicemail?      Yes      No

\*\*\* Please turn this sheet over and complete the survey and return it to the doctor \*\*\*

Provider use:

Date: \_\_\_\_\_ Provider name: \_\_\_\_\_

Action taken: \_\_\_\_\_ Faxed to Maternal Outreach Mood Services, fax (650) 448-1417

\_\_\_\_\_ Results called in to Maternal Outreach Mood Services (650) 988-8468

\_\_\_\_\_ No action required

\_\_\_\_\_ Other action taken: \_\_\_\_\_

Altos Pediatric Associates/Stanford Children's Health  
842 Altos Oaks Drive  
Los Altos CA 94024  
Phone: (650) 941-0550  
Fax: (650) 941-6751