



Review of Systems

Please place a check mark next to any of the following symptoms that apply to the patient’s current health.

General:

- Fever _____
- Fatigue _____
- Weight Loss _____

Eyes:

- Blurred Vision _____
- Eye Pain _____
- Glasses _____

Ear/Nose/Throat:

- Ear Pain _____
- Decreased Hearing _____
- Nosebleeds _____
- Nasal Congestion _____
- Runny Nose _____
- Sore Throat _____
- Hoarseness _____
- Difficulty Swallowing _____

Respiratory:

- Cough _____
- Wheezing _____
- Shortness of Breath _____

Cardiovascular:

- Heart Murmur _____
- Chest Pain _____
- Irregular Heart Beat _____
- Blood Pressure Problem _____

Gastrointestinal:

- Abdominal Pain _____
- Nausea _____
- Vomiting _____
- Diarrhea _____
- Constipation _____
- Blood in Stool _____
- Heartburn _____

Genitourinary:

- Pain with Urination _____
- Blood in Urine _____
- Frequent Urination _____
- Bedwetting _____

Endocrine:

- Hair Loss _____
- Cold/Heat Intolerance _____
- Abnormal Period _____

Skin:

- Rash _____
- Acne _____

Hematology:

- Easy Bleeding _____
- Easy Bruising _____
- Anemia _____

Musculoskeletal:

- Bone Pain _____
- Back Pain _____
- Swollen Joint _____
- Muscle Pain _____

Neurological:

- Headache _____
- Seizures _____
- Dizziness _____
- Numbness _____

Allergic:

- Food Allergy _____
- Medication Allergy _____

Edinburgh Postnatal Depression Scale¹ (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 | *6. Things have been getting on top of me |
| <input type="checkbox"/> As much as I always could | <input type="checkbox"/> Yes, most of the time I haven't been able to cope at all |
| <input type="checkbox"/> Not quite so much now | <input type="checkbox"/> Yes, sometimes I haven't been coping as well as usual |
| <input type="checkbox"/> Definitely not so much now | <input type="checkbox"/> No, most of the time I have coped quite well |
| <input type="checkbox"/> Not at all | <input type="checkbox"/> No, I have been coping as well as ever |
| 2. I have looked forward with enjoyment to things | *7. I have been so unhappy that I have had difficulty sleeping |
| <input type="checkbox"/> As much as I ever did | <input type="checkbox"/> Yes, most of the time |
| <input type="checkbox"/> Rather less than I used to | <input type="checkbox"/> Yes, sometimes |
| <input type="checkbox"/> Definitely less than I used to | <input type="checkbox"/> Not very often |
| <input type="checkbox"/> Hardly at all | <input type="checkbox"/> No, not at all |
| *3. I have blamed myself unnecessarily when things went wrong | *8. I have felt sad or miserable |
| <input type="checkbox"/> Yes, most of the time | <input type="checkbox"/> Yes, most of the time |
| <input type="checkbox"/> Yes, some of the time | <input type="checkbox"/> Yes, quite often |
| <input type="checkbox"/> Not very often | <input type="checkbox"/> Not very often |
| <input type="checkbox"/> No, never | <input type="checkbox"/> No, not at all |
| 4. I have been anxious or worried for no good reason | *9. I have been so unhappy that I have been crying |
| <input type="checkbox"/> No, not at all | <input type="checkbox"/> Yes, most of the time |
| <input type="checkbox"/> Hardly ever | <input type="checkbox"/> Yes, quite often |
| <input type="checkbox"/> Yes, sometimes | <input type="checkbox"/> Only occasionally |
| <input type="checkbox"/> Yes, very often | <input type="checkbox"/> No, never |
| *5. I have felt scared or panicky for no very good reason | *10. The thought of harming myself has occurred to me |
| <input type="checkbox"/> Yes, quite a lot | <input type="checkbox"/> Yes, quite often |
| <input type="checkbox"/> Yes, sometimes | <input type="checkbox"/> Sometimes |
| <input type="checkbox"/> No, not much | <input type="checkbox"/> Hardly ever |
| <input type="checkbox"/> No, not at all | <input type="checkbox"/> Never |

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, 194-199

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2 Month Questionnaire

1 month 0 days
through 2 months 30 days

On the following pages are questions about activities babies may do. Your baby may have already done some of the activities described here, and there may be some your baby has not begun doing yet. For each item, please fill in the circle that indicates whether your baby is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- Try each activity with your baby before marking a response.
- Make completing this questionnaire a game that is fun for you and your baby.
- Make sure your baby is rested and fed.
- Please return this questionnaire by _____.

Notes:

COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. Does your baby sometimes make throaty or gurgling sounds?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. Does your baby make cooing sounds such as "ooo," "gah," and "aah"?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. When you speak to your baby, does she make sounds back to you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
4. Does your baby smile when you talk to him?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
5. Does your baby chuckle softly?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
6. After you have been out of sight, does your baby smile or get excited when she sees you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___

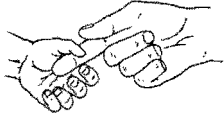


COMMUNICATION TOTAL _____

GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. While your baby is on his back, does he wave his arms and legs, wiggle, and squirm?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. When your baby is on her tummy, does she turn her head to the side?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. When your baby is on his tummy, does he hold his head up longer than a few seconds?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
4. When your baby is on her back, does she kick her legs?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
5. While your baby is on his back, does he move his head from side to side?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
6. After holding her head up while on her tummy, does your baby lay her head back down on the floor, rather than let it drop or fall forward?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___

GROSS MOTOR TOTAL _____


FINE MOTOR

- | | YES | SOMETIMES | NOT YET | |
|---|---|-----------------------|-----------------------|------|
| 1. Is your baby's hand usually tightly closed when he is awake? (If your baby used to do this but no longer does, mark "yes.") | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 2. Does your baby grasp your finger if you touch the palm of her hand? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| |  | | | |
| 3. When you put a toy in his hand, does your baby hold it in his hand briefly? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| |  | | | |
| 4. Does your baby touch her face with her hands? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 5. Does your baby hold his hands open or partly open when he is awake (rather than in fists, as they were when he was a newborn)? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___* |
| |  | | | |
| 6. Does your baby grab or scratch at her clothes? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |

FINE MOTOR TOTAL

**If Fine Motor item 5 is marked "yes," mark Fine Motor item 1 as "yes."*

PROBLEM SOLVING

- | | YES | SOMETIMES | NOT YET | |
|---|---|-----------------------|-----------------------|-----|
| 1. Does your baby look at objects that are 8–10 inches away? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 2. When you move around, does your baby follow you with his eyes? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 3. When you move a toy slowly from side to side in front of your baby's face (about 10 inches away), does your baby follow the toy with her eyes, sometimes turning her head? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 4. When you move a small toy up and down slowly in front of your baby's face (about 10 inches away), does your baby follow the toy with his eyes? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 5. When you hold your baby in a sitting position, does she look at a toy (about the size of a cup or rattle) that you place on the table or floor in front of her? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 6. When you dangle a toy above your baby while he is lying on his back, does he wave his arms toward the toy? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| |  | | | |

PROBLEM SOLVING TOTAL

PERSONAL-SOCIAL

- | | YES | SOMETIMES | NOT YET | |
|--|-----------------------|-----------------------|-----------------------|-----|
| 1. Does your baby sometimes try to suck, even when she's not feeding? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 2. Does your baby cry when he is hungry, wet, tired, or wants to be held? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 3. Does your baby smile at you? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 4. When you smile at your baby, does she smile back? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 5. Does your baby watch his hands? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |
| 6. When your baby sees the breast or bottle, does she seem to know she is about to be fed? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | ___ |



PERSONAL-SOCIAL TOTAL ___

OVERALL

Parents and providers may use the space below for additional comments.

1. Did your baby pass the newborn hearing screening test? If no, explain: YES NO

Empty rounded rectangular box for explanation.

2. Does your baby move both hands and both legs equally well? If no, explain: YES NO

Empty rounded rectangular box for explanation.

3. Does either parent have a family history of childhood deafness, hearing impairment, or vision problems? If yes, explain: YES NO

Empty rounded rectangular box for explanation.

OVERALL (continued)

4. Has your baby had any medical problems? If yes, explain:

YES

NO

5. Do you have concerns about your baby's behavior (for example, eating, sleeping)? If yes, explain:

YES

NO

6. Does anything about your baby worry you? If yes, explain:

YES

NO