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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 Scale[1] (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
- ☐ 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

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4 Month Questionnaire

3 months 0 days through 4 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:

____

____

____

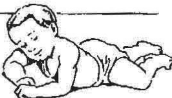
____

COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. Does your baby chuckle softly?	○	○	○	___
2. After you have been out of sight, does your baby smile or get excited when he sees you?	○	○	○	___
3. Does your baby stop crying when she hears a voice other than yours?	○	○	○	___
4. Does your baby make high-pitched squeals?	○	○	○	___
5. Does your baby laugh?	○	○	○	___
6. Does your baby make sounds when looking at toys or people?	○	○	○	___

COMMUNICATION TOTAL ___

GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. While your baby is on his back, does he move his head from side to side?	○	○	○	___
2. 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?	○	○	○	___
3. When your baby is on his tummy, does he hold his head up so that his chin is about 3 inches from the floor for at least 15 seconds? 	○	○	○	___
4. When your baby is on her tummy, does she hold her head straight up, looking around? *(She can rest on her arms while doing this.)*	○	○	○	___

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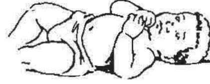
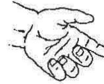
GROSS MOTOR (continued)

	YES	SOMETIMES	NOT YET	
5. When you hold him in a sitting position, does your baby hold his head steady?	○	○	○	___
6. While your baby is on her back, does your baby bring her hands together over her chest, touching her fingers? 	○	○	○	___
		GROSS MOTOR TOTAL		___

FINE MOTOR

	YES	SOMETIMES	NOT YET	
1. Does your baby hold his hands open or partly open (rather than in fists, as they were when he was a newborn)? 	○	○	○	___
2. When you put a toy in her hand, does your baby wave it about, at least briefly?	○	○	○	___
3. Does your baby grab or scratch at his clothes?	○	○	○	___
4. When you put a toy in her hand, does your baby hold onto it for about 1 minute while looking at it, waving it about, or trying to chew it?	○	○	○	___
5. Does your baby grab or scratch his fingers on a surface in front of him, either while being held in a sitting position or when he is on his tummy?	○	○	○	___
6. When you hold your baby in a sitting position, does she reach for a toy on a table close by, even though her hand may not touch it?	○	○	○	___
		FINE MOTOR TOTAL		___

PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	
1. 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 his eyes, sometimes turning his head?	○	○	○	___
2. 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 her eyes?	○	○	○	___
3. When you hold your baby in a sitting position, does he look at a toy (about the size of a cup or rattle) that you place on the table or floor in front of him?	○	○	○	___
4. When you put a toy in her hand, does your baby look at it?	○	○	○	___
5. When you put a toy in his hand, does your baby put the toy in his mouth?	○	○	○	___

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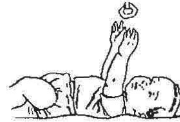
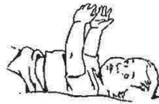
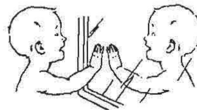
PROBLEM SOLVING *(continued)*

	YES	SOMETIMES	NOT YET	
6. When you dangle a toy above your baby while she is lying on her back, does your baby wave her arms toward the toy? 	○	○	○	___
		PROBLEM SOLVING TOTAL		___

PERSONAL-SOCIAL

	YES	SOMETIMES	NOT YET	
1. Does your baby watch his hands? 	○	○	○	___
2. When your baby has her hands together, does she play with her fingers?	○	○	○	___
3. When your baby sees the breast or bottle, does he seem to know he is about to be fed?	○	○	○	___
4. Does your baby help hold the bottle with both hands at once, or when nursing, does she hold the breast with her free hand?	○	○	○	___
5. Before you smile or talk to your baby, does he smile when he sees you nearby?	○	○	○	___
6. When in front of a large mirror, does your baby smile or coo at herself? 	○	○	○	___
		PERSONAL-SOCIAL TOTAL		___

OVERALL

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

1. Does your baby use both hands and both legs equally well? If no, explain: ○ YES ○ NO

2. When you help your baby stand, are his feet flat on the surface most of the time? If no, explain: ○ YES ○ NO

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OVERALL (continued)

3. Do you have concerns that your baby is too quiet or does not make sounds like other babies? If yes, explain: ◯ YES ◯ NO

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

5. Do you have concerns about your baby's vision? If yes, explain: ◯ YES ◯ NO

6. Has your baby had any medical problems in the last several months? If yes, explain: ◯ YES ◯ NO

7. Do you have any concerns about your baby's behavior? If yes, explain: ◯ YES ◯ NO

8. Does anything about your baby worry you? If yes, explain: ◯ YES ◯ NO

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