Pediatric Associates of Lagrange
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Congratulations on your new bundle of joy. Oftentimes along with joy come feelings of sadness or being overwhelmed. Our office cares about your family and wants you to know we are here for you. It is recommended by the American Academy of Pediatrics to screen parents for postpartum depression. Our office wants to be supportive of efforts to address postpartum issues. We will ask you to complete this screening tool at newborn through your baby's first year visits. Depending on your score, we have resources that we can offer you if you have any signs of postpartum depression or just need to talk to someone about what you're feeling.

Postpartum depression is not the same as baby blues, which you may be familiar with. Postpartum depression lasts longer and is more serious than baby blues. Baby blues are feelings of sadness you may have in the first few days after having a baby. Baby blues can happen 2 to 3 days after you have your baby and can last up to 2 weeks. You may have trouble sleeping, be moody or cranky, and cry a lot. Postpartum depression (also called PPD) is a kind of depression that some women get after having a baby. It is strong feelings of sadness, anxiety (worry) and tiredness that last for a long time after giving birth. These feelings can make it hard for you to take care of yourself and your baby. PPD can happen any time after childbirth, but it often starts within 1 to 3 weeks of having a baby. Please remember PPD is not your fault and you didn't do anything to cause PPD. It doesn't make you a bad person or a bad mother. You are not alone. Please feel free to reach out to us since up to 1 in 7 women has PPD after giving birth, and it's the most common complication for women who have just had a baby. It's a medical condition that needs treatment to get better. If you have feelings that last longer than 2 weeks or if something doesn't seem right, call your healthcare provider.

With your permission we will share your scores with your OB/GYN. If needed, we will also give you information regarding resources and support networks.

☐ Permission to share with my OB/GYN or Primary Care Provider:

Name: _____ Phone: _____

☐ My contact information may be shared with referral sources:

Referral Source Name: _____ Phone: _____

Signature: _____ Date: _____

Print your name: _____

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

Patient Name:_____

Tuberculosis (TB) Risk Assessment

Circle Yes or No

			*If Yes, please explain
1. Is the child in close contact to a person with active TB disease?*	Yes	No	_____
2. Does the child have or is at risk to have HIV?	Yes	No	_____
3. Was the child or the child's parent born outside the US?	Yes	No	_____
4. Is the child exposed to a person in jail or a person who has been in jail in the past five years?	Yes	No	_____
5. Is the child exposed to a person who has HIV, who is homeless or who lives in nursing home or another group home?	Yes	No	_____
6. Is the child exposed to drug users or migrant farm workers?	Yes	No	_____
7. Does the child have a health problem that lowers the immune system?	Yes	No	_____
8. Does the child live in a community that has a high risk for TB?	Yes	No	_____
9. Has the child traveled to or had any visitors from any foreign country since the last visit?	Yes	No	_____
10. Does the child have any symptoms of TB (cough, fever, night sweats, loss of appetite, weight loss or fatigue) or an abnormal chest x-ray?*	Yes	No	_____

*** Call the Health Department**

Vision Risk Assessment Questionnaire

Circle Yes or No

			*If Yes, please explain
1. Has anyone in your child's family been diagnosed with congenital cateracts, retinoblastoma, metabolic disease, or ocular abnormalities?	Yes	No	_____
2. Has anyone in your child's family been diagnosed with amblyopia (blurred vision) or strabismus (lazy eye)?	Yes	No	_____
3. Has anyone in your child's family been diagnosed with epiphoria (excessive watery eyes), photophobia (light sensitivity), ptosis (drooping of the upper eyelid), or anisocoria (unequal pupil size)?	Yes	No	_____
4. Has anyone in your child's family had glaucoma, eye surgery, or glasses	Yes	No	_____
5. Do your child's eyes appear unusual?	Yes	No	_____
6. Does your child seem not to see well?	Yes	No	_____
7. Does your child exhibit difficulty with near or distance vision?	Yes	No	_____
8. Do your child's eyes appear not to be straight?	Yes	No	_____
9. Do your child's eyelids droop or does one eyelid tend to close?	Yes	No	_____
10. Has your child ever had an eye injury?	Yes	No	_____

Parent Signature _____ Date _____

Please check the box and sign if there have been no changes to the above answers since the last checkup.

☐ Parent Signature_____ Witness _____ Date _____

☐ Parent Signature_____ Witness _____ Date _____

☐ Parent Signature_____ Witness _____ Date _____

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Patient Name: _____

Lead Risk Assessment Questionnaire

Circle Yes or No

			*If Yes, please explain
1. Does your child live in or often visit a house that may have been built before 1978?	Yes	No	_____
2. Does your child live in or often visit a house that is being remodeled or is having paint removed?	Yes	No	_____
3. Does your child live with or often visit another child that has an elevated blood lead level?	Yes	No	_____
4. Does your child live with anyone that works at a job where lead may be found or has a hobby that uses it?	Yes	No	_____
5. Does your child chew on or eat any non-food items like paint chips or dirt?	Yes	No	_____
6. Does your child live near an active lead smelter, battery recycling plant or other industry likely to release lead?	Yes	No	_____
7. Does your child receive medicines such as *greta, azarcon,kohl or pay-loo-ah*?	Yes	No	_____

Risk Factors for Hearing Loss

1. Parent or caregiver concern regarding hearing, speech, language, or developmental delay	Yes	No
2. Family history of permanent childhood hearing loss	Yes	No
3. NICU stay greater than five days, ECMO, ototoxic medications, loop diuretics, exchange transfusion	Yes	No
4. In utero infections such as CMV, herpes, rubella, syphilis, Toxoplasmosis	Yes	No
5. Craniofacial anomalies, especially involving the ear and temporal bone	Yes	No
6. Stigmata of syndromes known to cause hearing loss, Eustachian tube dysfunction	Yes	No
7. Syndromes associated with hearing loss or progressive or late-onset hearing loss	Yes	No
8. Neurodegenerative disorders or sensory motor neuropathies	Yes	No
9. Postnatal infections associated with sensorineural hearing loss including bacterial meningitis	Yes	No
10. Head trauma	Yes	No
11. Chemotherapy	Yes	No
12. Recurrent or persistent ear infection for at least 3 months	Yes	No

Parent Signature _____ Date _____

Please check the box and sign if there have been no changes to the above answers since the last checkup.

☐ Parent Signature_____ Witness _____ Date _____

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