2 Month Questionnaire

Patient's Name: _____

Personal/Social History

Are you concerned about your baby's...

1. Feedings? ☐ Yes ☐ No
   ☐ Breast ☐ Formula
2. Excessive spitting, vomiting, or back arching with feedings? ☐ Yes ☐ No
3. Bowel movements? ☐ Yes ☐ No
4. Nasal stuffiness, congestion or wheezing? ☐ Yes ☐ No
5. Skin color or rashes (circle one)? ☐ Yes ☐ No
6. Crying more than 3 hours a day? ☐ Yes ☐ No
7. Sleep habits ☐ Yes ☐ No
8. Growth ☐ Yes ☐ No
9. Development? ☐ Yes ☐ No

Answer the following:

10. Is your child exposed to tobacco smoke? ☐ Yes ☐ No
11. Have you been depressed or crying lately? ☐ Yes ☐ No
12. Are your infants bowel movements white or gray or blood streaked? ☐ Yes ☐ No
13. Does your baby co-sleep with you? ☐ Yes ☐ No
14. Has your child traveled out of the country or do you plan to take your child to a country OTHER THAN Western Europe, Canada, Australia, or New Zealand in the next year? ☐ Yes ☐ No

Does your child...

15. Smile at the sound of your voice or seeing your face? ☐ Yes ☐ No
16. Coo or vocalize when you talk to him/her? ☐ Yes ☐ No
17. Watch you as you walk across the room? ☐ Yes ☐ No
18. Startle at loud noises? ☐ Yes ☐ No
19. Turn his/her head toward the direction of sound? ☐ Yes ☐ No
20. Move all extremities equally well? ☐ Yes ☐ No
21. Hold head upright for a short time? ☐ Yes ☐ No
22. Bottle fed infants: Is your child getting over 30 ounces per day? ☐ Yes ☐ No

Answer the following:

23. Do you have any help with the baby? ☐ Yes ☐ No
24. Are you getting enough rest? ☐ Yes ☐ No
25. Does your child ride in a rear-facing infant car seat? ☐ Yes ☐ No
26. Do you know infant CPR? ☐ Yes ☐ No
27. Does your baby sleep with a pacifier? ☐ Yes ☐ No
28. Does your baby sleep on his/her back? ☐ Yes ☐ No
29. Have both parents/caregivers had the Tdap vaccine? ☐ Yes ☐ No
30. September through March visits: Have all caregivers and family members living in the home been vaccinated with the flu vaccine this season? ☐ Yes ☐ No

2 Month Questionnaire

Breast Feeding Infants:

Please answer the questions below if your infant is breast fed:

1. Are you giving vitamin D? ..... ☐ Yes ☐ No
2. Breast feeding mothers, are you taking a multivitamin with iron? ..... ☐ Yes ☐ No
3. Are you having any problems nursing? ..... ☐ Yes ☐ No
4. Do you need help from our lactation specialists? ..... ☐ Yes ☐ No
5. Do you need help with preparations to return to work? ..... ☐ Yes ☐ No

Screening questions for Tuberculosis:

1. Do you have a family member with TB or any contact with someone who has TB? ..... ☐ Yes ☐ No
2. Do any family members have a positive TB test? ..... ☐ Yes ☐ No
3. Was your child or any family member born in a high risk country (any country other than the US, Canada, Australia, New Zealand, or Western Europe)? ..... ☐ Yes ☐ No
4. Has your child or a family member traveled to a high risk country and had contact with resident populations for over 1 week? ..... ☐ Yes ☐ No
5. Has your child ever drank unpasteurized milk? ..... ☐ Yes ☐ No

Synagis Screening: (Immunization against RSV recommended by the AAP). Mark "yes" if any apply:

1. Your infant is less than 12 months old with chronic lung or congenital heart disease ..... ☐ Yes ☐ No
2. Your infant was a preemie of 28 weeks or less and is less than 12 months old ..... ☐ Yes ☐ No
3. Your infant is less than 2 years old and has chronic lung disease needing oxygen, Albuterol, diuretics or chronic steroid use in the last 6 months ..... ☐ Yes ☐ No
4. Your infant is less than 12 months old and has a congenital airway abnormality or neuromuscular disorder ..... ☐ Yes ☐ No
5. Your infant is less than 12 months old and has Cystic Fibrosis with nutritional compromise ..... ☐ Yes ☐ No
6. Your infant is under 2 years old and is profoundly immunocompromised or is undergoing a heart transplant ..... ☐ Yes ☐ No

Name and Ages of Brothers _____

Sisters _____

Patient lives with: Mom _____ Dad _____ Both Together _____ Both Separately _____

Do you have any concerns you wish to discuss? ..... ☐ Yes ☐ No

_____

_____

_____

_____

_____

_____

Edinburgh Postnatal Depression Scale[1] (EPDS)

Patient's Name: _____ Patient's Date of Birth: _____

Your Name: _____ Address: _____

Your DOB: _____ _____

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 closes 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
   - ☐ No, not at all
   - ☐ Hardly ever
   - ☐ Yes, sometimes
   - ☐ Yes, very often

*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 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/Reviewedby: _____ 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

Name: _____ Date:

HITS (HURT, INSULT, THREATEN, SCREAM) SCREENING TOOL FOR DOMESTIC VIOLENCE

Place a CHECK MARK (✓) next to the answer that indicates the frequency in which your partner acts in the way depicted in this past **month**.

Please speak to your health care provider if need help, regardless of the score.

This screening tool will help identify if extra support is needed. resources below

1. HOW OFTEN DOES YOUR PARTNER PHYSICALLY HURT YOU?

Never	_____	(1)
Rarely	_____	(2)
Sometimes	_____	(3)
Fairly often	_____	(4)
Frequently	_____	(5)

2. HOW OFTEN DOES YOUR PARTNER INSULT OR TALK DOWN TO YOU?

Never	_____	(1)
Rarely	_____	(2)
Sometimes	_____	(3)
Fairly often	_____	(4)
Frequently	_____	(5)

3. HOW OFTEN DOES YOUR PARTNER THREATEN YOU WITH HARM?

Never	_____	(1)
Rarely	_____	(2)
Sometimes	_____	(3)
Fairly often	_____	(4)
Frequently	_____	(5)

4. HOW OFTEN DOES YOUR PARTNER SCREAM OR CURSE AT YOU?

Never	_____	(1)
Rarely	_____	(2)
Sometimes	_____	(3)
Fairly often	_____	(4)
Frequently	_____	(5)

A score of greater than 10 is considered positive.

Virginia Chapter
Incorporated in Virginia
American Academy of Pediatrics

VDH VIRGINIA DEPARTMENT OF HEALTH

FINAL SCORE:

Sherin KM, Sinacore JM, Li XQ, Zitter RE, Shakil A. HITS: a short domestic violence screening tool for use in a family practice setting. Fam Med. 1998 Jul-Aug;30(7):508-12.