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 — 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
   - ☐ 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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Edinburgh Postnatal Depression Scale[1] (EPDS)

Postpartum depression is the most common complication of childbearing.[2] The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for "perinatal" depression. The EPDS is easy to administer and has proven to be an effective screening tool.

Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt ***during the previous week***. In doubtful cases it may be useful to repeat the tool after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

Women with postpartum depression need not feel alone. They may find useful information on the web sites of the National Women's Health Information Center <www.4women.gov> and from groups such as Postpartum Support International <www.chss.iup.edu/postpartum> and Depression after Delivery <www.depressionafterdelivery.com>.

SCORING

QUESTIONS 1, 2, & 4 (without an *)
Are scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.

QUESTIONS 3, 5-10 (marked with an *)
Are reverse scored, with the top box scored as a 3 and the bottom box scored as 0.

Maximum score: 30
Possible Depression: 10 or greater
Always look at item 10 (suicidal thoughts)

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Instructions for using the Edinburgh Postnatal Depression Scale:

1. The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days.
2. All the items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers come from the mother or pregnant woman.)
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

[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.

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OB COMPREHENSIVE MEDICAL HISTORY

Name ____

Medical History

Have you Had?	If Yes, Date		Have you Had?	If Yes, Date
Anemia			HIV	
Anesthesia complications			Infertility	
Anorexia			Kidney problem/disease *(specify)*	
Arthritis			Kidney infection	
Asthma			Liver problem/disease *(specify)*	
Autoimmune disease			Lung problem/disease *(specify)*	
Birth defects			Major accident	
Bladder infection			Measles	
Blood disorders/disease *(specify)*			Migraines	
Blood transfusion			Mitral Valve Prolapse	
Cancer *(specify)*			Mono	
Chickenpox			Ovarian Cysts/growths	
Chlamydia			Infection of uterus/tubes/ovaries	
Depression			Psychiatric disorder *(specify)*	
Deep Vein Thrombosis			Rheumatic fever	
Diabetes			Syphilis	
Epilepsy			Thyroid problems/disease *(specify)*	
Gastrointestinal problem/disease			Tuberculosis	
Genital herpes			Varicose Veins	
Genital warts			Abnormal Pap Smear	
Gonorrhea			Uterine growths/fibroids	
Hay fever/seasonal allergies			Uterine/Cervical Abnormality	
Heart Problem/disease *(specify)*			Pap Smear *(Date of last pap)*	
Hepatitis *(specify type)*			Mammogram *(Date of last Mammo)*	
High blood pressure			Thyroid testing *(Date of last testing)*	

Your family doctor: ___________________________________ Pediatrician: ____

Surgical History

Date	List of all previous hospitalizations, surgeries, and procedures

Are you adopted? No Yes If yes, do you know your family history? No Yes

Family Medical History

Has any blood relative ever had:	Maternal Relative *(If Yes, Specify)*	Paternal Relative *(If Yes, Specify)*	Has any blood relative ever had:	Maternal Relative *(If Yes, Specify)*	Paternal Relative *(If Yes, Specify)*
Asthma			Hay fever/Allergies		
Birth Defect			Heart disease *(specify)*		
Blood Disorder			Hepatitis *(specify type)*		
Cancer *(specify)*			High blood pressure		
Deep Vein Thrombosis			Liver disease		
Diabetes			Kidney disease *(specify)*		
Gastrointestinal Disease			Psychiatric disease		
Goiter			Thyroid disease		
			Tuberculosis		

Genetic History

Please check if you, your partner, your blood relatives, or his blood relatives ever had:

	Yourself	List Family Member
Cerebral Palsy		
Congenital birth defects		
Cystic fibrosis		
Down syndrome		
Mental retardation		
Neural tube defect		
Sickle cell disease		
Twins		
Triplets		
Are you and your partner blood relatives?		

Your ethnic background:	Your partner's ethnic background:
Father of your baby's name:	Relationship:
How old is the father of your baby?	Is this your first child together? YES NO

Social History

Highest Level of Education	
Grade School	years
High School	years
College	years
Postgraduate	years

Religion ____________________

Occupation ____________________

Do you have cats? YES NO

Marital Status (circle)

Single Married

Engaged Divorced

Substance Use	Never	Usual amount used before pregnancy	Amount used since known to be pregnant
Caffeine			
Tobacco			
Alcohol			
Drugs			

Have you ever used drugs or alcohol during pregnancy? YES NO

Have you had a problem with drugs or alcohol in the past? YES NO

In the month before you knew you were pregnant how often did you use? ____________

Does your partner have a problem with drugs or alcohol? YES NO

Do you consider one of your parents to be an addict or alcoholic? YES NO

Sexual History					
More than one partner in the last 12 months?	YES	NO	**History of sexual abuse?**	YES	NO
More than 3 partners in lifetime?	YES	NO	**History of physical abuse?**	YES	NO

Pregnancy History **Have you ever been pregnant?** **YES** **NO** **Please list all pregnancies**

Delivery Date	Mo. Along	Vag. or C-Section	Complications	Living Y/N

Have you ever had a miscarriage or abortion? **YES** **NO** **Please list all miscarriages**

Date	Wks Along	Miscarriage	Abortion	Complications

Menstrual History

First day of your last period? **Are you certain?** YES NO **Did you have a normal flow?** YES NO

How often do you have periods? Every ________ days	**Have you had a positive home pregnancy test?** YES NO **If so, when?**
How long do they last? ____________ days	
Typical Flow (circle): Light Moderate Heavy	**Have you had an HCG or progesterone test done with this pregnancy?** YES NO
Age at very first period:	
Last contraceptive used: ____________	**Have you had a flu shot this year?** YES NO
When?	**Have you had a COVID vaccine?** YES NO

Current Pregnancy History	
In *this* pregnancy, have you had:	**If yes, please give details**
Headaches	
Dizziness	
Nausea	
Vomiting	
Vaginal Discharge	
Vaginal spotting or bleeding	
Urinary Complaints	
Swelling of feet, ankles, hands, or face	
Fever	
Cold or Flu	
Rash	
Exposure to X-ray	
Exposure to communicable disease	
Non-prescription drugs	
Prescription drugs	
Preferred Pharmacy:	**What was your weight when you got pregnant?**

List all current medications: ____

List all medication allergies: ____

ID# ________________

Staff Initials _________

PATIENT INFORMATION FORM

First and Last Name	Maiden (if married)	Date of Birth	Social Security Number
Address	City	State	Zip

Ethnicity ☐ Hispanic ☐ Not Hispanic	Race	☐Married ☐Divorced ☐Single ☐Widowed	Primary Language	Religion

Employer	Occupation
Primary Care Physician/Location	Are we authorized to fax any office notes they request to them? ☐Yes ☐No

Cell Phone Number	Home Phone Number	Email Address

I give my permission to South Shore Women's Health Care staff to call and leave detailed information regarding my appointment, test results, prescriptions, outstanding balance, or care in a message on the following phone(s):

☐ Home Phone **☐ Cell Phone** **☐ Patient Portal**

I would prefer to receive my appointment reminders by: ☐ Text Message or ☐ Email or ☐ Patient Portal

*Standard text messaging fees may apply depending on your cellular service plan

☐ Spouse or ☐ Guardian Information *(Guardian information required for patients under 18 years old)*

Full Name	Date of Birth	Phone

May we speak with them about your health? ☐Yes ☐No	Do you want them as your emergency contact? ☐Yes ☐No

INSURANCE

Primary Insurance	Policy Holder *(if different from you)*	Their Date of Birth	Relationship to you
Secondary Insurance	Policy Holder *(if different from you)*	Their Date of Birth	Relationship to you

HIPAA

In accordance with Federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPAA), in order for your healthcare provider or staff of *South Shore Women's Health Care* to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

First and Last Name	Relationship	Phone Number	Do you want them as your emergency contact?
			☐Yes ☐No
			☐Yes ☐No

Patient Information: I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed. I understand that the information disclosed to any above recipient is no longer protected by federal or state law and may be subject to disclosure by the above recipient. You have the right to revoke this consent in writing. My signature below signifies that I have read and understand South Shore Women's Health Care's financial and HIPAA (protected health information) policy. Furthermore, it acknowledges my responsibility regarding charges related to my care.

Patient/Guardian Signature ____ Date: ___________________

Patient/Guardian's Printed Name ______________________________________