NL Health Services

Name: _____

HCN: _____

Date of Birth: _____

Newfoundland and Labrador Prenatal Record (Part I)

Date completed: _____ DD/MM/YYYY

Demographics

Last name	First name	Gender	Pronoun

Address	Contact Telephone: _____ Alternate Telephone: _____	Leave message ☐Yes ☐No	MCP

Date of birth DD/MM/YYYY	Age at EDD	Highest level of education completed	Employed ☐Yes ☐No	Occupation	Culture/beliefs/practices

Language: ☐English ☐French ☐Arabic ☐Other: _____ ☐Interpreter required	Indigenous identity: ☐Yes ☐No ☐ Innu ☐ Inuit ☐ Mi'kmaq ☐ _____	Relationship status: _____ Partner involved: ☐Yes ☐No

Partner's name	Gender	Age	Partner employed ☐Yes ☐No	Occupation	Support person: ☐Yes ☐No Name: _____

Prenatal care provider(s)	Baby's care provider in hospital	Primary care provider	Baby's care provider in community

Pregnancy Dating

EDD (FINAL): DD/MM/YYYY

Last menstrual period (LMP) DD/MM/YYYY	EDD by LMP DD/MM/YYYY	Dating U/S DD/MM/YYYY	Gestational Age (GA)	EDD by U/S DD/MM/YYYY	Assisted Reproductive Technology (ART): ☐Yes ☐No Type: _____	EDD by ART DD/MM/YYYY

Length of cycle: _____ Regular: ☐Yes ☐No Certain of dates: ☐Yes ☐No Planned pregnancy: ☐Yes ☐No	Multiple pregnancy: ☐Yes ☐No	Chorionicity	Embryo Transfer DD/MM/YYYY

Obstetrical History

Gravida _____ **T**erm _____ **P**reterm _____ **A**bortus _____ **L**iving children _____ **S**tillbirth _____

Date	Place of birth	Gest. age	Type of birth	Complications/Comments e.g. PPH, GDM, IUGR, etc.	Birth Weight	Sex	Current Health	Breastfeeding Duration
DD/MM/YYYY								
DD/MM/YYYY								
DD/MM/YYYY								
DD/MM/YYYY								
DD/MM/YYYY								
DD/MM/YYYY								

Health History

Allergies (include reaction) ☐ Latex ☐NKDA	Previous surgery ☐ Yes ☐No	Medications

	Yes	No
Anesthesia comp.	☐	☐
Blood transfusion	☐	☐
Respiratory	☐	☐
Cardiovascular	☐	☐
☐ Hypertension		
☐ Previous GHTN		
Neurology	☐	☐
Hematology	☐	☐

Infectious diseases	Yes	No
	☐	☐
☐ HSV ☐ HIV ☐ HBV ☐HCV		
☐ Syphilis ☐Gonorrhea ☐ Chlamydia ☐Other		
MSK/Rheumatology	☐	☐
Gynecology/Breast	☐	☐
Gastrointestinal/Liver	☐	☐
Renal/Genitourinary	☐	☐
Endocrine	☐	☐
☐ Thyroid ☐ Previous GDM ☐T1DM ☐T2DM		

Mental Health	Yes	No
	☐	☐
☐ Anxiety		
☐ Depression		
☐ Previous PPD		
☐ Bipolar		
☐ Eating disorder		
☐ Schizophrenia		
☐ Other: _____		

Family History	Yes	No
	☐	☐
☐ Anesthesia comp.		
☐ Diabetes		
☐ Hypertension		
☐ Thromboembolic		
☐ Mental health		
☐ Coagulopathies		
☐ Other: _____		

Comments

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NL Health Services

Name: _____

HCN: _____

Date of Birth: _____

Newfoundland and Labrador Prenatal Record (Part II)

Date completed _____ DD/MM/YYYY

Current Pregnancy

	Yes	No		Yes	No		Yes	No	Comments
Nausea/vomiting	☐	☐	Travel (self/partner)	☐	☐	Calcium/vitamin D	☐	☐	
Illness/rash/fever	☐	☐	Preconception folic acid	☐	☐				
Bleeding	☐	☐	Prenatal vitamins	☐	☐				

Infant feeding plan: ☐Breastfeeding ☐Human Milk Substitute ☐Undecided

Clinical Exam

Height	Weight	Pre-pregnancy BMI	Recommended gestational weight management see worksheet 1	Comments

BP	Lungs	Heart	Abdomen	Pelvic exam	Female genital cutting ☐Yes ☐No

Lifestyle/Risk Factors

	Yes	No		Yes	No		Yes	No		Yes	No
Relationship issues	☐	☐	Financial/housing issues	☐	☐	Parenting concerns	☐	☐	Dietary restrictions/concerns	☐	☐
History of trauma/abuse	☐	☐	Barriers accessing care	☐	☐	Occupational risks	☐	☐	Food security concerns	☐	☐
Intimate partner violence	☐	☐	Social support concerns	☐	☐	Oral hygiene concerns	☐	☐	Other	☐	☐

Substance Use

	Yes	No
Tobacco - past 6 months Number of cigs/day _____ Quit DD/MM/YYYY	☐	☐
Tobacco - current use Number of cigs/day _____ ☐Ceremonial	☐	☐
Nicotine replacement	☐	☐
Vaping during pregnancy	☐	☐
Cannabis - past 6 months	☐	☐
Cannabis - current use	☐	☐
Number of times used/day _____ /week _____		
Method _____		
Strength _____		

	Yes	No
Alcohol - past 6 months Number per week _____ Last drink DD/MM/YYYY	☐	☐
Alcohol - current use Number of drinks/day _____ /week _____	☐	☐
≥4 drinks at one time	☐	☐
Other Substance use in pregnancy ☐Cocaine ☐Methamphetamines ☐Opioids ☐Other	☐	☐
Route _____		
Substance use disorder ☐Opioid agonist therapy	☐	☐
_____		

Comments/Follow-up

Ethnicity

Black	☐	White	☐
East Asian	☐	Unknown	☐
Indigenous	☐	Prefer not to say	☐
Latin American	☐		
Middle Eastern	☐	Other (specify)	☐
Southeast Asian	☐		
South Asian	☐	_____	

Genetic Risk Assessment

	Yes	No
Donor gamete: Egg	☐	☐
Sperm	☐	☐

Egg age at EDD_____

_____
Ethnicity gamete

Hemoglobinopathy/Thalassemia screen (CBC, Hgb electrophoresis)	Consanguinity (blood relation)
☐Yes ☐No ☐N/A	☐Yes ☐No

Referral to Medical Genetics (see worksheet 2):
☐ Yes ☐ No ☐ N/A ☐ Declined
Specify

Genetic Screening/Investigations (See worksheet 2)

No genetic screening ☐Counseled and declined

NT (11-13+6 weeks)	☐Counseled	☐Completed	☐Declined	☐N/A	NIPT	☐Counseled	☐MCP	☐Self pay ☐Declined
MSS (15-20+6 weeks)	☐Counseled	☐Completed	☐Declined		CVS/Amniocentesis		☐Yes	☐No
EPR	☐Counseled	☐Completed	☐Declined	☐N/A	Other		☐Yes	☐No

Comments

NLHS076AUG25

NL Health Services

Name: _____

HCN: _____

Date of Birth: _____

Newfoundland and Labrador Prenatal Record (Part III)

For additional information refer to the "Guidelines for Prenatal Screening and Testing in Newfoundland and Labrador"

Ultrasound/Biophysical Profile

Date	GA	Results	Date	GA	Results
DD/MM/YYYY			DD/MM/YYYY		
DD/MM/YYYY			DD/MM/YYYY		
DD/MM/YYYY			DD/MM/YYYY		
DD/MM/YYYY			DD/MM/YYYY		

Initial Lab Investigations

Test	Results	Date DD/MMM/YYYY
Hemoglobin		DD/MM/YYYY
Platelets		DD/MM/YYYY
ABO/Rh (D)		DD/MM/YYYY
Antibody Screen	☐Negative ☐ Positive	DD/MM/YYYY
Hemoglobin A1c		DD/MM/YYYY
Fasting Plasma Glucose	☐NA	DD/MM/YYYY
Syphilis**	☐Non-reactive ☐Reactive	DD/MM/YYYY
Gonorrhea **	☐Negative ☐Positive	DD/MM/YYYY
Chlamydia**	☐Negative ☐Positive	DD/MM/YYYY
HBsAg**	☐Non-reactive ☐Reactive	DD/MM/YYYY
HCV Ab	☐Non-reactive ☐Reactive	DD/MM/YYYY
HIV**	☐Non-reactive ☐Reactive	DD/MM/YYYY
Urine C&S		DD/MM/YYYY
Varicella*	☐Immune ☐Non-immune	DD/MM/YYYY
Rubella*	☐Immune ☐Non-immune	DD/MM/YYYY
Pap Due	☐Yes ☐No	DD/MM/YYYY
Last pap results	☐Normal ☐Abnormal	DD/MM/YYYY

24-28 Week Lab Investigations

Test	Results	Date (DD/MMM/YYYY)
Hemoglobin		DD/MM/YYYY
Platelets		DD/MM/YYYY
ABO/Rh (D)		DD/MM/YYYY
Repeat Antibodies	☐ Negative ☐ Positive	DD/MM/YYYY
GCT 50 g	1 hour_____ ☐ **GDM**	DD/MM/YYYY
OGTT 75 g	☐ NA Fasting_____ 1 hour_____ 2 hour_____ ☐ **GDM**	DD/MM/YYYY
Third Trimester Lab Investigations		
Syphilis** (28-32 weeks***)	☐ Non-reactive ☐ Reactive	DD/MM/YYYY
Gonorrhea**	☐ Negative ☐ Positive	DD/MM/YYYY
Chlamydia**	☐ Negative ☐ Positive	DD/MM/YYYY
Group B Strep (35-37 weeks)	☐ Negative ☐ Positive	DD/MM/YYYY

* Perform serology if immunity unknown
** Consider additional screening for those at ongoing risk of infection
*** Or as close to this interval as possible

Additional Tests (as indicated)

Ferritin	☐ NA	
TSH	☐ NA	

Screening Tool Results (see worksheets 3 and 4)

WAST ☐Negative ☐Positive	EPDS score	EPDS score	EPDS score	T-ACE score ☐N/A as no alcohol consumed
Date DD/MM/YYYY	Date DD/MM/YYYY	Date DD/MM/YYYY	Date DD/MM/YYYY	Date DD/MM/YYYY

Rh CARE ☐NA

☐ Rh (D) Neg
Rh (D) Alloimmunization ☐Yes ☐ No

☐ Rho(D) IG (28-29+6 weeks) Date DD/MM/YYYY

☐ Additional Rho(D) given Date DD/MM/YYYY

Bleeding/other event in pregnancy ☐Yes ☐ No
_____weeks

Public Health Referral and Recommended Vaccines

☐ Refer all pregnant people to Public Health for immunization, prenatal education and support.

Influenza vaccine ☐N/A Date DD/MM/YYYY
Covid vaccine ☐N/A Date DD/MM/YYYY
Tdap vaccine at 27-32 weeks Date DD/MM/YYYY
Hepatitis B vaccine (if at risk) ☐N/A Date DD/MM/YYYY
Other _____ Date DD/MM/YYYY

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NL Health Services

Name: _____

HCN: _____

Date of Birth: _____

Newfoundland and Labrador Prenatal Record (Part IV)

Use 'Additional Prenatal Visits' page when additional space is required.
Refer to the "Newfoundland and Labrador Prenatal Record Companion Document".

Issues/Management Plan

EDD (FINAL) DD/MM/YYYY

☐ HSV treatment indicated ☐Low dose aspirin indicated ☐Progesterone (preterm birth prevention) indicated
☐ Social concerns (adoption, child protection, etc.)

Referral follow up:
☐ Obstetrics ☐ Medical Genetics ☐Anesthesia ☐Diabetic Educator ☐Dietician ☐Public Health Nurse
☐ Neonatology ☐ Pediatrics ☐ Mental Health ☐Social Work ☐Other _____

At approximately 36 weeks: Copy of prenatal record to ☐ hospital and/or with ☐ patient

Prenatal Visits **G**ravida_____ **T**erm_____ **P**reterm_____ **A**bortus_____ **L**iving children_____ **S**tillbirth_____

Date	Weight (kg)	BP	GA	Fundal height	Fetal HR	FM	Presentation/ Position	Cig/ day	**Comments**: e.g. IPV, mental health, substance use	Next visit	Initials
DD/MM/YYYY											
DD/MM/YYYY											
DD/MM/YYYY											
DD/MM/YYYY											
DD/MM/YYYY											
DD/MM/YYYY											
DD/MM/YYYY											
DD/MM/YYYY											

Care Provider Signature

Print name	Signature	Initials

Print name	Signature	Initials

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NL Health Services

Name: _____

HCN: _____

Date of Birth: _____

Newfoundland and Labrador Prenatal Record (Part V)

Additional Prenatal Visits

Issues/Management Plan

EDD (FINAL) _____DD/MM/YYYY_____

Prenatal Visits **G**ravida_____ **T**erm_____ **P**reterm_____ **A**bortus_____ **L**iving children_____ **S**tillbirth_____

Date	Weight (kg)	BP	GA	Fundal height	Fetal HR	FM	Presentation/ Position	Cig/ day	Comments: e.g. IPV, mental health, substance use	Next visit	Initials
DD/MM/YYYY											
DD/MM/YYYY											
DD/MM/YYYY											
DD/MM/YYYY											
DD/MM/YYYY											
DD/MM/YYYY											
DD/MM/YYYY											
DD/MM/YYYY											
DD/MM/YYYY											
DD/MM/YYYY											
DD/MM/YYYY											
DD/MM/YYYY											
DD/MM/YYYY											

Care Provider Signature

Print name	Signature	Initials

Print name	Signature	Initials

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NL Health Services

Name: _____

HCN: _____

Date of Birth: _____

Newfoundland and Labrador Prenatal Record (Part VI)

Additional Prenatal Visits

Issues/Management Plan

EDD (FINAL) _____DD/MM/YYYY_____

Prenatal Visits **G**ravida_____ **T**erm_____ **P**reterm_____ **A**bortus_____ **L**iving children_____ **S**tillbirth_____

Date (DD/MMM/YYYY)	Weight (kg)	BP	GA	Fundal height	Fetal HR	FM	Presentation/ Position	Cig/ day	Comments: e.g. IPV, mental health, substance use	Next visit	Initials
DD/MM/YYYY											
DD/MM/YYYY											
DD/MM/YYYY											
DD/MM/YYYY											
DD/MM/YYYY											
DD/MM/YYYY											
DD/MM/YYYY											
DD/MM/YYYY											
DD/MM/YYYY											
DD/MM/YYYY											
DD/MM/YYYY											
DD/MM/YYYY											
DD/MM/YYYY											

Care Provider Signature

Print name	Signature	Initials

Print name	Signature	Initials

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NL Health Services

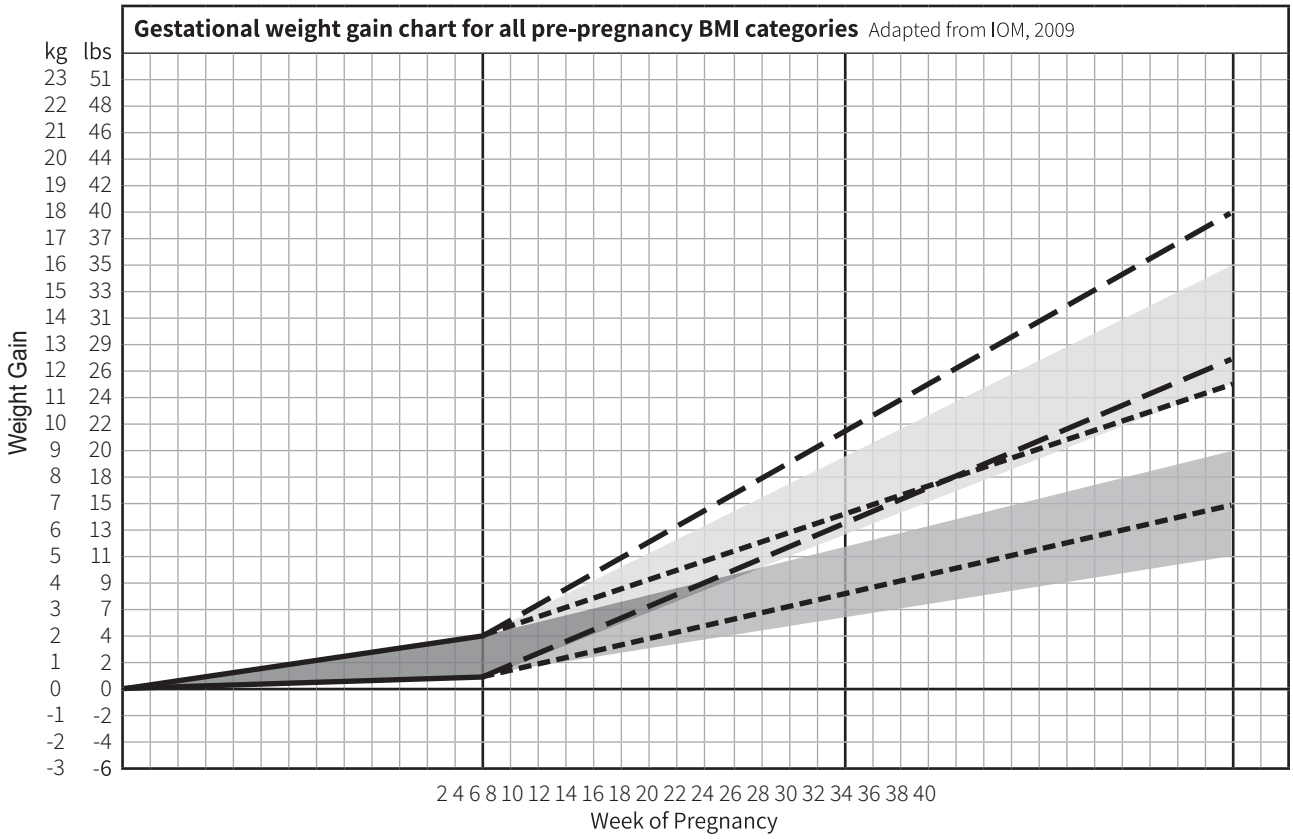
Name: _____

HCN: _____

Date of Birth: _____

Newfoundland and Labrador Prenatal Record (Part VII)

Worksheet 1 Height _____ **Weight** _____ **Pre-Pregnancy BMI** _____ **Recommended total weight gain** _____



Legend	Prepregnancy BMI	Recommend total weight gain	GWG/week in 2nd 3rd trimester
— —	< 18.5 kg/m²	12.5-18 kg (28-40 lbs)	0.5 kg (1-1.3 lbs)
	18.5-24.9 kg/m²	11.5-16 kg (25-35 lbs)	0.4kg (0.8-1 lbs)
- - - - -	25-29.9 kg/m²	7.5-11.5 (15-25 lbs)	0.3 kg (0.5-0.7 lbs)
	>30 kg/m²	5-9 kg (11-20 lbs)	0.2 kg (0.4-0.6 lbs)

The y axis represents gestational weight gain (the 0 is the pre-pregnancy weight). The x axis represents weeks of pregnancy. Plot the accumulated weight gain on the along the y axis, above the weeks of pregnancy along the x axis.

Care Considerations for Increased Pre-Pregnancy BMI

Pre-pregnancy BMI ≥ 30 kg/m²

- FPG and/or HgbA1C with initial bloodwork
- Dating U/S
- U/S for fetal growth at 28, 32, 36 weeks
- Start ASA 162 mg and 1000mg Calcium (dietary or supplemental)

If Pre-pregnancy BMI ≥ 40 kg/m², include the following:

- Consider anesthesia consult to assess risks/delivery planning
- Weekly biophysical at 36 weeks
- Thyroid screening with initial blood work
- Plan for delivery at 39-40 weeks.

5A's of Healthy Pregnancy weight gain

Ask – for permission to talk about weight
Assess – potential root cause
Advise – pregnancy weight gain risk and options
Agree – on a realistic SMART plan to achieve healthy behaviour outcomes
Assist – in identifying barriers and facilitators

If weight gain is below or above recommendations:

Assess for clinical issues (such as edema) and explore the root causes of inappropriate weight gain, including
- **Mental** (e.g. insomnia)
- **Metabolic** (e.g. medications)
- **Mechanical** (e.g. reduced mobility)
- **Milieu** (e.g. employment)

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NL Health Services

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Date of Birth: _____

Newfoundland and Labrador Prenatal Record (Part VIII)

Worksheet 2

Genetic Screening and Assessment[1]

All pregnant persons and their partners should have a three-generation family history taken family history taken by their primary care provider. One's ethnicity is an important piece of risk assessment as some populations are known to have a higher incidence of certain genetic conditions, such as:

☐ Ashkenazi Jewish (Tay Sachs, Canavan, Familial dysautonomia)

☐ French Canadian from Saguenay Lac-St Jean, Charlevoix, Bas-St-Laurent (Tay Sachs, CF)

Referral to Medical Genetics should be considered for those from higher risk populations and those with a personal or family history of:

- Congenital anomaly e.g. congenital heart defect, neural tube defect
- Intellectual disability or developmental delay
- Genetic syndrome e.g. neurofibromatosis, Noonan syndrome
- Chromosomal disorder e.g. Down syndrome (trisomy 21), familial translocation
- Muscular disorder e.g. X-linked Duchenne and Becker muscular dystrophies
- Bleeding disorder e.g. X-linked hemophilia A or B
- Recurrent miscarriage
- Sudden unexplained death
- Other major health concerns such as cardiomyopathy, neurological disease, epilepsy, hearing loss, autism, and psychiatric disorders
- Consanguinity

Hemoglobinopathies
- α thalassemia
- β thalassemia
- Sickle cell disease

Screening recommendations

Offer to individuals from the following at-risk populations/ethnic backgrounds when red blood cell indices reveal a mean cellular volume (MCV) < 80 fl OR electrophoresis reveals an abnormal hemoglobin type

- African
- Mediterranean
- Middle East
- South East Asian
- Western Pacific
- Caribbean
- South American

Method of carrier screening:

- Complete blood count
- Hemoglobin (Hb) electrophoresis (HE) or Hb high performance liquid chromatography (HHPLC)
- Quantification of Hb alpha 2 and fetal Hb
- Serum ferritin if microcytosis (MCV <80 fl) and/or hypochromia (mean cellular Hb <27 pg) in the presence of a normal HE or HHPLC assessment

Refer for genetic consultation if both members of a couple are carriers of the same type of thalassemia OR a combination of thalassemia and hemoglobin variant.

Hemoglobinopathy screening should be repeated for individuals previously screened with a point of care test (e.g. sickle cell disease) given an increased frequency of false negative results.

For information about prenatal aneuploidy screening, including Maternal Serum Screening (MSS), and Non-Invasive Prenatal Screening (NIPT), please refer to the companion guide.

[1] Wilson, R. and De Bei, I. (2016) Joint SOGC–CCMG Opinion for Reproductive Genetic Carrier Screening: An Update for All Canadian Providers of Maternity and Reproductive Healthcare in the Era of Direct-to-Consumer Testing. Retrieved from: https://www.jogc.com/article/S1701-2163(16)39347-1/pdf

NL Health Services

Name: _____

HCN: _____

Date of Birth: _____

Newfoundland and Labrador Prenatal Record (Part IX)

Worksheet 3

T-ACE Alcohol Screening Tool[1]

The T-ACE screening tool is a measurement tool of four questions that are significant identifiers of pregnancy risk drinking (i.e., there is no known safe amount of alcohol intake to consume during pregnancy.)

The T-ACE score has a range of 0-5. The value of each answer to the four questions is totalled to determine the final T-ACE score.

A total score of 2 or more indicates a positive outcome for pregnancy risk drinking and the pregnant person should be referred for further assessment.

Screening is not required if initial assessment reveals no alcohol is consumed.

One drink is equivalent to:12 ounces of beer or cooler; 5 ounces of wine; 1.5 ounces of hard liquor

Tolerance	How many drinks does it take to make you feel high?	≤ 2 drinks = 0 > 2 drinks = 2	_____ score
Annoyed	Have people annoyed you by criticizing your drinking?	Yes = 1 No = 0	_____ score
Cut Down	Have you felt you ought to cut down on your drinking?	Yes = 1 No = 0	_____ score
Eye Opener	Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?	Yes = 1 No = 0	_____ score
		Total Score:	_____

Women Abuse Screening Tool (WAST)[2]

The WAST specifically screens for verbal, emotional, physical, and sexual abuse and is used to help determine if the pregnant person is experiencing domestic violence. Consider the WAST with an inclusive context. Despite the title alluding to women, this tool should be used to screen all pregnant people for risk of domestic violence regardless of gender identity. If the answers to questions 1 and 2 are “a lot of tension” and “great difficulty” the screen is considered positive and the remaining 6 questions should be answered.

1. In general how would you describe your relationship?	☐ **A lot of tension**	☐ **Some tension**	☐ **No tension**
2. Do you and your partner work out your arguments with?	☐ **Great difficulty**	☐ **Some difficulty**	☐ **No tension**
3. Do arguments ever result in you feeling down or bad about yourself?	☐ Often	☐ Sometimes	☐ Never
4. Do arguments ever result in hitting, kicking, or pushing?	☐ Often	☐ Sometimes	☐ Never
5. Do you ever feel frightened by what your partner says or does?	☐ Often	☐ Sometimes	☐ Never
6. Has your partner ever abused you physically?	☐ Often	☐ Sometimes	☐ Never
7. Has your partner ever abused you emotionally?	☐ Often	☐ Sometimes	☐ Never
8. Has your partner ever abused you sexually?	☐ Often	☐ Sometimes	☐ Never

1 Sokol, J., Martier, S., Ager, J. (1989). The T-ACE questions: practical prenatal detection of risk-drinking. American Journal of Obstetrics and Gynecology, 160(4):863-870.

2 Brown, J., Lent, B., Brett, P, Sas, G. and Pedersen, L. (1996). Development of the Woman Abuse Screening Tool for use in family practice. Family Medicine, 28, 422 -28.

NL Health Services

Name: _____

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Date of Birth: _____

Newfoundland and Labrador Prenatal Record (Part X)

Worksheet 4

Edinburgh Perinatal/Postnatal Depression Scale (EPDS)[1]

Depression is the most common complication of childbearing. The 10-question EPDS is a valuable and efficient way of identifying patients at risk for perinatal depression. Pregnant persons who score above 13 are likely to be suffering from a depressive illness of varying severity. A careful clinical assessment should be carried out to confirm the diagnosis. Consider other causes for symptoms such as anemia, poor sleep, and lack of energy. Thyroid dysfunction, anemia, or bereavement should be excluded before diagnosing a depression.

Perform screening using the EPDS ideally once in each trimester of pregnancy.

0 to 10	Monitor
11-13	Monitor, support, and provide education. Repeat EPDS in 2 weeks time. If still elevated, refer for further assessment.
≥ 14	Requires further assessment, diagnosis, and appropriate management as the likelihood of depression is high. Referral to a psychiatrist/ psychologist may be necessary.
Item #10	Any individual who scores 1, 2, or 3 on item 10 requires further evaluation before leaving the care provider's office to ensure their own safety and that of their baby.

In the presence of a negative EPDS screen, using a score of 5 or greater on the anxiety specific EPDS questions (4, 5, 6) may be helpful in identifying those who could benefit from further anxiety screening and treatment.

In the past 7 days

1. I have been able to laugh and see the funny side of things
   - 0 ☐ As much as I always could
   - 1 ☐ Not quite so much now
   - 2 ☐ Definitely not so much now
   - 3 ☐ Not at all

2. I have looked forward with enjoyment to things
   - 0 ☐ As much as I ever did
   - 1 ☐ Rather less than I used to
   - 2 ☐ Definitely less than I used to
   - 3 ☐ Hardly at all

3. I have blamed myself unnecessarily when things went wrong
   - 3 ☐ Yes, most of the time
   - 2 ☐ Yes, some of the time
   - 1 ☐ Not very often
   - 0 ☐ No, never

4. I have been anxious or worried for no good reason
   - 0 ☐ No, not at all
   - 1 ☐ Hardly ever
   - 2 ☐ Yes, sometimes
   - 3 ☐ Yes, very often

5. I have felt scared or panicky for no very good reason
   - 3 ☐ Yes, quite a lot
   - 2 ☐ Yes, sometimes
   - 1 ☐ No, not much
   - 0 ☐ No, not at all

6. Things have been getting on top of me
   - 3 ☐ Yes, most of the time I haven't been able to cope
   - 2 ☐ Yes, sometimes I haven't been coping as well as usual
   - 1 ☐ No, most of the time I have coped quite well
   - 0 ☐ No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping
   - 3 ☐ Yes, most of the time
   - 2 ☐ Yes, sometimes
   - 1 ☐ Not very often
   - 0 ☐ No, not at all

8. I have felt sad or miserable
   - 3 ☐ Yes, most of the time
   - 2 ☐ Yes, quite often
   - 1 ☐ Not very often
   - 0 ☐ No, not at all

9. I have been so unhappy that I have been crying
   - 3 ☐ Yes, most of the time
   - 2 ☐ Yes, quite often
   - 1 ☐ Only occasionally
   - 0 ☐ No, never

10. The thought of harming myself has occurred to me
    - 3 ☐ Yes, quite often
    - 2 ☐ Sometimes
    - 1 ☐ Hardly ever
    - 0 ☐ Never

Total Score _____

1 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.