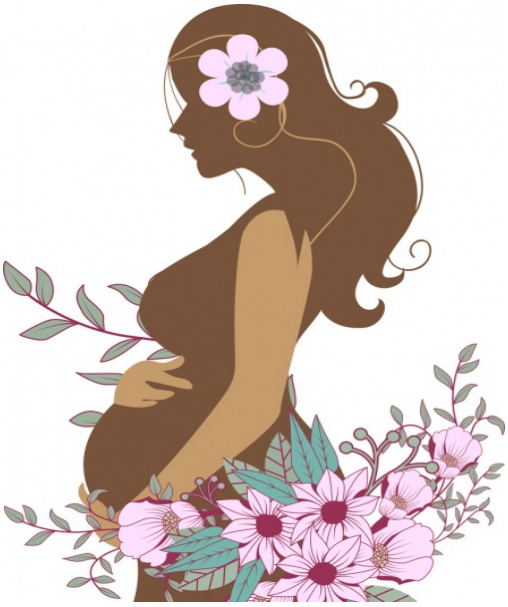
Tripler Army Medical Center

&

Schofield Barracks

Department of Obstetrics

OB Registration Packet



Please complete every page **ENTIRELY** prior to your scheduled OB REG appointment time.

If packet is not completed, registration appointment may need to be rescheduled.

Tripler Army Medical Center OB and Schofield Barracks OB

Appointment Line: 433-2778, Option 3, 7, then 1

Dear OB Patient,

Congratulations from the staff of Tripler Army Medical Center and Schofield Barracks OB/GYN Clinics! We would like to share what you can expect when receiving care with us, as well as explain the different care options that are available to you.

The first appointment that must be completed by all patients is the OB Registration Appointment. This appointment is conducted by a nurse who will review your completed registration packet, schedule your physical appointment, order laboratory tests, and conduct teaching regarding nutrition, exercise, support services, and signs to report immediately. At this appointment, your nurse will ask if you have considered your prenatal care options. The options available to you are:

1. **OB Physician Care**: available for complicated and uncomplicated care at Tripler Army Medical Center for the duration of your pregnancy as well as your delivery.
2. **Nurse Practitioner Care**: available for uncomplicated care at Tripler Army Medical Center and Schofield Barracks for your pregnancy. Your delivery will be managed by a physician.
3. **Certified Nurse Midwife**: available for uncomplicated care at Tripler Army Medical Center for the duration of your pregnancy as well as your delivery. You must meet specific criteria in order to be enrolled. This program is limited to women who have a low risk of needing any intervention during delivery.
4. **Centering Pregnancy**: available for uncomplicated care at Tripler Army Medical Center. This form of prenatal care is conducted in a group, with time included for one on one time with the provider. These groups are facilitated by a Certified Nurse Midwife or a Nurse Practitioner. At the group sessions, you will conduct a physical check-up, learn valuable self- care and infant care skills, discuss common pregnancy complaints and solutions, and build a strong sense of community with the other women in the group. This is an exciting program with many benefits to the participants. Please see our homepage, Facebook page, or call our Centering Coordinator for more information. Our Centering Coordinator can be reached at 808-433-4593, or by calling the main line at 808-433-2778 option 3, 7 then 1, and asking for the Centering Coordinator.

Your next appointment will be conducted with a Physician, Nurse Practitioner, or a Certified Nurse Midwife. Your ultrasound will be done at 20 weeks.

If you have any questions or concerns, please contact our **Advice Nurse at 808-433-2778 option 3, 7 then 1.** Please leave a message with your name, your sponsor's social security number, your phone, and why you are calling.

The **Same Day Evaluation Clinic** (SDEC) at Tripler is available for any of the following problems:

Vaginal bleeding with cramping

Repeated nausea and vomiting for greater than 24 hours

Burning on urination

Fever greater than 100.5

Same Day Evaluation Clinic Hours: M, W, Th, F 0800-1500, *Tue 0800-1130.
Please go to the Emergency Department for any issues after hours or for the following emergencies:

Major car accident

Broken bones

Chest pain

Trouble breathing

Non-obstetrical emergencies

To SCHEDULE an appointment, please call 808-433-2778, option 3, 3, then 2.

To CANCEL an appointment, please call 808-433-1177 or 808-433-1164

Your appointment is scheduled on _____ at _____
(date) (time)
with _____ at Tripler Army Medical Center / Schofield Barracks.
(provider)

Please fill this packet out COMPLETELY. If you are transferring care (have received care for this pregnancy at another facility) please bring your records with you. A copy will be made and the original will be given back to you.

We look forward to meeting you!

Childcare Options

Children are welcome at many of the appointments that you will attend during your prenatal care; however, we ask that you find childcare for the following appointments:

1. *Anatomy Ultrasound (20 week ultrasound)*
2. *Any appointments in the Antepartum Diagnostic Center (ADC) to include non-stress tests, fluid checks, dating ultrasounds, etc.*
3. *Centering sessions*

We understand that it can be very difficult to arrange for childcare for these appointments. Here are some of the childcare options available to you:

1. **Armed Services YMCA Children's Waiting Room at Tripler AMC-** Care is available in 2 hour increments from Monday-Friday, 8am-12pm, and 12pm-3:30pm for children 6 weeks to 12 years old. Children must be registered, in good health, and up-to-date on their shots. Children must wear closed-toe shoes. Reservations are preferred. Please call 808-433-3270 for registration and reservation information. This program is run on monetary donations.
2. **Child Development Centers-** Care is provided on a part-time, full-time, after-school, and drop-in basis, as space is available. Children must be registered and be up-to-date on their shots. Registration can be done at Schofield Barracks (Army, 655-5314), Aliamanu Military Reservation (Army, 833-5393), Hickam (Air Force, 449-9880), Pearl Harbor (Navy, 473-2669), or MCBH (Marines, 257-8354). Please visit www.himwr.com/child-development-centers, www.greatlifehawaii.com, or www.mccshawaii.com/cdc for more information.
3. **PATCH-** PATCH is Hawaii's statewide child care resource and referral agency. This agency provides parents with information and resources needed when looking for quality care for their children. This is a free service. For more information call 839-1988 or visit www.patchhawaii.org.

If you are unable to arrange childcare and will miss your appointment, please call our appointment line as soon as possible to cancel your appointment and to reschedule.

OB Registration

Please fill this form out completely before your appointment with the nurse.

Your Last Name | **First Name** | **Sponsor's SSN**

Marital Status Married

Ethnicity Caucasion

OTHER:

Check one: (you are)

☐ Dependent

☐ Active Duty _____ (O-1, E-1, etc)

Your Date of Birth

Primary Language _____

Religious Preference _____

Sponsor's:

Branch of Service: _____

Base/Post Stationed at:

Military Unit: _____

Husband / Sponsor's Last Name | **First Name** | **Date of Birth** ___/___/___ | **Check one**

Dependent

Active Duty _____ (O-1, E-1, etc)

Father of Baby is

☐ Aware of my pregnancy

☐ Supportive of my pregnancy

Father's Ethnicity: Caucasion

Address:

Street

City, State, Zip

Home Phone | **Work Phone** | **Email**

PCS/DEROS:

Please rank the following according to your daily use:

Smoking: (per day)	Never	Light < one pack	Moderate 1-1.5 pack	Heavy 1.5-2 packs	Very Heavy >2 packs
Illicit Drug Used:	Never	Light 1-2 times/year	Moderate 3-4	Heavy 4-5	Very Heavy >5
Alcoholic Beverages:	Never	Light 1-2 drinks/month	Moderate 3-4	Heavy 4-5	Very Heavy >5
Caffeinated Beverages:	Never	Light 1-2 times/day	Moderate 3-4	Heavy 4-5	Very Heavy >5

I am taking: ☐ Prenatal ☐ Iron Supplements ☐ Folic Acid

Please list any other medications, vitamins or herbal supplements that you take on a regular basis.

Please let us know if **you** have any problems with the following parts of your body by checking the block and giving a short description, to include dates.

GENERAL

HEAD/MIGRAINES

EYES/GLASSES/CONTACTS

EAR

NOSE

NECK

THROAT

LUNGS

HEART

STOMACH/INTESTINES/BOWEL MOVEMENTS

URINARY/KIDNEYS/URINARY TRACT INFECTIONS

GYN/UTERUS/OVARIES/CERVIX/ABNORMAL PAP SMEARS

BLOOD/ANEMIA/SICKLE CELL/HEPATITIS

LYMPH

MUSCLES/BACK

NEURO/PSYCH/ANXIETY/DEPRESSION/EATING DISORDERS

HISTORY DRUG/ALCOHOL ABUSE TREATMENT

OTHER

Please check the box if **<u>you</u> have ever been treated** for any of the following: (Include dates)

HYPERTENSION/PRE-ECLAMPSIA

HERPES

SEXUALLY TRANSMITTED DISEASES

BLOOD TRANSFUSION

MORE THAN TWO URINARY TRACT INFECTIONS IN ONE YEAR

SEIZURE

THYROID PROBLEMS

ASTHMA

DIABETES

CARDIAC PROBLEMS

PULMONARY PROBLEMS / TUBERCULOSIS (TB)

Do you own any cats? ☐ YES ☐ NO

Please check the box if **<u>you</u>** have a family history of any of the following.
If you do , state the relationship to you. **<u>Remember, we only need to know if it is on your side of the family.</u>**

TWINS

BIRTH DEFECTS

DIABETES

CANCER

HEART DISEASE

HIGH BLOOD PRESSURE

Are you allergic to any food or medication? ☐ YES ☐ NO

If yes, please write what you are allergic to and what happens to you.

I have had the following childhood illnesses:
(Please check the appropriate box or boxes.)

☐ NONE ☐ CHICKEN POX ☐ MEASLES ☐ MUMPS ☐ RHEUMATIC FEVER

Please list any past operations/surgeries that you have had.
Include the month and year they occurred.

First day of your last menstrual period: _____ Height: Usual Weight: _____

Including this pregnancy, how many times have you been pregnant? _____

How many children do you have now? _____

How old were you when you had your first period? _____

Are your periods ☐ REGULAR ☐ IRREGULAR

How often did your periods occur? Every _____days.

Rate the amount of pain that you experience with your menstrual cycle.

☐ NONE ☐ MILD ☐ MILD-MODERATE ☐ MODERATE ☐ SEVERE ☐ IRREGULAR

How many days do you bleed for during your menstrual period?

Past Pregnancies: Please fill out the chart below. Include any miscarriage or elective terminations that you have had.

Date	How many weeks you were at delivery	Hours of labor	Type of Anesthesia Used	Vaginal, C/S, Forceps, Vacuum	Hospital and State	Sex of Baby	Weight	Any Complications/ Hospitalizations During Pregnancy/Medication

Have you ever had a positive Tuberculosis or TB Tine Test? ☐ YES ☐ NO If yes, when: _____

Were you born outside of the United States? ☐ YES ☐ NO If yes, where: _____

Have you ever lived outside of the United States for more than 30 days? ☐ YES ☐ NO

Have you ever had active TB or lived with someone with active TB? ☐ YES ☐ NO

Have you ever taken any medications for TB? ☐ YES ☐ NO If yes, when: _____

If so, what medication(s) _____ How long? _____

Is this a planned pregnancy? ☐ Yes ☐ No

Are you experiencing any: ☐ NAUSEA ☐ VOMITING ☐ CRAMPING ☐ BLEEDING

How will you feed your baby? ☐ BREAST FEED ☐ BOTTLE FEED ☐ UNDECIDED

How would you describe your appetite? _____

Are you on any kind of special diet? ☐ NO ☐ YES. What kind? _____

Do you have any food cravings? ☐ NO ☐ YES. They are _____

Do you avoid any foods? ☐ NO ☐ YES. They are _____

How many times do you eat in one day? _____

What topic(s) do you want/need education on?

Prenatal Care	Home Visiting Nurse
Childbirth Preparation Classes	Couples Counseling
Breastfeeding	Individual Counseling
Infant Care	Stress/Anger Management
Labor and Delivery Tour	Financial Planning
WIC	Single Parents Group
Sibling Classes	Domestic Violence Treatment

What is the best method of learning for you? ☐ Reading ☐ Videos ☐ Computer ☐ Demonstration

What is the highest school grade that you have completed?

Do you have any chronic pain issues/concerns?

_____

Do you have any financial hardships that prevent you from getting medical care?

Do you have any cultural, language or religious preferences that would affect your care?

Ifyes: _____

During the past month, have you often been bothered by feeling down, depressed or hopeless?

During the past month, have you often been bothered by little interest or pleasure in doing things?

Do you have an Advance Medical Directive?

If no, are you interested in receiving information?

All information gathered JAW The Privacy Act of 1974.

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA For the use of this form, see AR 40-66; the proponent agency is The Office of the Surgeon General.	
REPORT TITLE **TAMC Prenatal Genetic Screen***	OTSG APPROVED *(Date)* *(20071025) 4NOV1987*

1. Will you be 35 years or older when the baby is due?

2. Have you, the baby's father, or anyone in either of your families ever had the following disorders?
   a. Down Syndrome
   b. Other chromosomal abnormality
   c. Neural tube defect, i.e., spina bifida (meningomyelocele or open spine), anencephaly
   d. Hemophilia
   e. Muscular dystrophy
   f. Cystic fibrosis
   g. If yes, indicate the relationship of the affected person to you or the baby's father: _____

3. Do you or the baby's father have a birth defect?
   a. If yes, who has the defect and what is it? _____

4. In any previous marriages, have you or the baby's father had a child, born dead or alive, with a birth defect not listed in question 2 above?

5. Do you or the baby's father have any close relatives with mental retardation?
   a. If yes, indicate the relationship of the affected person to you or to the baby's father: _____
   b. Indicate the cause, if known: _____

6. Do you, the baby's father, or a close relative in either of your families have a birth defect, any familial disorder, or a chromosomal abnormality not listed above?
   a. If yes, indicate the condition and the relationship of the affected person to you or thebaby's father: _____

7. In any previous marriages, have you or the baby's father had a stillborn child or three or more first-trimester spontaneous pregnancy losses?
   a. Have either of you had a chromosomal study?
   b. If yes, indicate who and the results: _____

8. If you or the baby's father are of Jewish ancestry, have either of you been screened for Tay-Sachs disease?
   a. If yes, indicate who and the results: _____

9. If you or the baby's father are black, have either of you been screened for sickle cell trait?
   a. If yes, indicate who and the results: _____

10. If you or the baby's father or Italian, Greek, or Mediterranean background, have either of you been tested for β-thalassemia?
    a. If yes, indicate who and the results: _____

11. If you or the baby's father are of Philippine or Southeast Asian ancestry, have either of you been tested for α-thalassemia?
    a. If yes, indicate who and the results: _____

12. Excluding iron and vitamins, have you taken any medications or recreational drugs since being pregnant or since your last menstrual period? (including non-prescription drugs)
    If yes, give name of medication: _____

Prepared by (signature & title)	DEPARTMENT/SERVICE/CLINIC	DATE (*YYYYMMDD*)
PATIENT'S IDENTIFICATION *(For a typed or written entries give: Name- -last, first, middle; grade; date; hospital or medical facility)*	HISTORY/PHYSICAL OTHER EXAMINATION OR EVALUATION DIAGNOSTIC STUDIES TREATMENT	FLOW CHART OTHER *(specify)*

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Popular Topics & Services

- Home Visits
- Safe Sleep
- Play Mornings
- Prenatal Wellness
- Behavior & Tantrums
- Breastfeeding
- Toilet Training
- Nutrition
- Development
- Fatherhood
- Infant Massage
- Military Family Issues
- Resources
- Single Parenting
- Information & Referrals

Hours of operation
Monday-Friday
7:30A.M. - 4:30P.M.

310 Brannon Road
Building 690
Schofield Barracks, HI 96857

Important Telephone Numbers

Emergency	911
Domestic Violence Help	808-624-SAFE
Poison Control Help	800-222-1222
Military One Source	800-342-9647
Military Information	808-449-7110

QC 01

U. S. Army Garrison - Hawaii
Army Community Service

NEW PARENT SUPPORT PROGRAM

808-787-4227

The New Parent Support Program (NPSP)

The New Parent Support Program is a professional team of nurses and social workers. We provide parenting support and education through home visits. Our staff is familiar with common parenting concerns and the unique challenges that military families face.

Who Is This For?

The New Parent Support Program is a voluntary program developed to support new parents in ways that family and friends often do. Military families who are expecting or who have a child ages zero through three years old are invited to participate free of charge.

What Can NPSP Do For Me?

The New Parent Support Program provides support and reassurance throughout a season of life that usually comes with many questions and uncertainties. We tailor home visits to the needs of each family and offer the opportunity for parents to build on and learn new parenting skills.

The New Parent Support Program will connect you with reliable information from trusted sources and provide education from evidence-based resources. Our home visitors help strengthen families, increase parent-child bonds, and support parents in providing a nurturing and safe environment for their infants and toddlers.

What If We're Not First-Time Parents?

You don't have to be a first-time parent to benefit from NPSP. Each age and stage brings with it a different challenge. You can share your concerns and receive assistance with questions about babies, toddlers, and family relationships.

NEW PARENT SUPPORT PROGRAM

How Often Will Home Visitors Meet With Me and My Family?

Home visitors will work with each family to establish a visiting schedule that meets the family's needs. Whether it be weekly, biweekly, or monthly, our home visitors will come to you to provide support and education in the convenience of your home.

ENROLL NOW

808-787-4227

(SEE PRIVACY ACT STATEMENT ON REVERSE)

NEW PARENT SUPPORT PROGRAMS HAWAII – CASE REFERRAL

To: *(name and location)*

New Parent Support Programs Hawaii *(NPSP Hawaii)*
Air Force: 449-0175
Army: 655-1670
Marine Corps: 257-8803
Navy: 473-4222 x 233

Referring Party: *(name, location, and contact Phone #)*

1. NAME OF PATIENT *(Last, First, Middle Initial)*
0

2. ADDRESS OF PATIENT *(Give specific directions)*

3. DATE OF BIRTH	4. AGE	5. HOME PHONE

6. PATIENT SSN:

7. NAME OF FATHER *(Last, First, Middle Initial)* DOB:	8. SPONSOR'S GRADE AND SSN	9. BRANCH OF SERVICE

10. SPONSOR'S ORGANIZATION	11. FATHER'S PHONE	12. MARITAL STATUS	13. FIRST TERM ENLISTMENT?
		Married	

14. SPONSORS LAST DEPOLYMENT:

PENDING DEPLOYMENT: Y / N

15. NUMBER OF PREGNANCIES: NUMBER OF CHILDREN:
Total number and attach face sheet with ages

CHILDREN WITH SPECIAL NEEDS:
IF YES, SPECIFCY:

16. ESTIMATED DUE DATE:

17. AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the release of the medical information relevant to this referral to the New Parent Support Program or the Armed Services (Well Baby) YMCA, Hawaii for planning of prenatal health services and parenting support.

_____ _____
SIGNATURE OF PATIENT *(or person authorized to consent for patient)* **DATE**

18. REASON FOR REFERRAL; OTHER SIGNIFICANT DATA

1. Number of Pregnancies: _____ Number & Ages of Children: _____
2. How are you feeling about being pregnant? _____ Partner: _____
3. What concerns or worries do you have? _____
4. What experiences do you have caring for a newborn baby? _____
5. Do you have parenting concerns? _____
6. Who do you have that you can depend on for help? _____
7. What do you do when you feel stressed or "frazzled"? _____
8. In a few words, what was your childhood like? _____
9. Have you ever been emotionally abused? ☐ No ☐ Yes When:_____ By Whom:_____
10. Have you ever been hit, slapped, kicked, pushed, or otherwise physically hurt in the past or during your pregnancy?
    ☐ No ☐ Yes When:_____ By Whom:_____
11. Have you ever experienced forced sexual activities?
    ☐ No ☐ Yes When:_____ By Whom:_____
12. If you were emotionally, physically, or sexually abused, how does it affect you now?
    _____
13. Have you had counseling? ☐ No ☐ Yes Do you want counseling now? ☐ No ☐ Yes
14. Do you feel safe in your home/personal relationship? ☐ No ☐ Yes
15. Have you had any previous involvement with FAP or Child Protective Services for child abuse or neglect? ☐ No ☐ Yes
    If Yes, when? _____
16. Do you or your spouse have a history of mental illness, i.e. depression? ☐ No ☐ Yes

Comments:

This form in and of itself DOES NOT constitute a contract with the Army for payment of services to be rendered.

19. REPORT OF FINDINGS AND RECOMMENDATIONS

20. SIGNATURE OF INDIVIDUAL COMPLETING ITEM #19

21. DATE

DATA REQUIRED BY THE PRIVACY ACT OF 1974

1. AUTHORITY: 5 US Code 301; 10 US Code 1071; 42 US Code; 44 US Code 3101.

2. PRINCIPAL PURPOSE(S): Provides a means for medical and allied medical personnel to refer individuals and families for Army community health nursing services.

3. ROUTINE USES:
   a. To refer patients or family units to other military and civilian health and welfare agencies or to Army community health nurses at other military installations.
   b. A case referral which contains medical information requires written consent of the patient or legal representative prior to release to a civilian agency.
   c. A doctor's signature is required when medication and/or treatments are ordered.
   d. To provide continuity of care, minimize duplication of effort and furnish accurate information to other health care providers.
   e. When case is completed or inactive, one copy of record is returned to the initiator (item 2, above) and duplicate copies of record are destroyed when no longer needed.

4. MANDATORY OR VOLUNTARY DISCLOSURE: Voluntary however failure to provide information may prevent continuity of care, cause duplication of effort and prevent accuracy of information to other health care providers.

TAMC's CENTERING PREGNANCY PROGRAM

Welcome to the TAMC OB/GYN Clinic! Thank you for your interest in the Centering Pregnancy Program.

The Centering Pregnancy Program is an innovative and cutting-edge way to get prenatal care. You will meet with other moms due in the same month for ten sessions during your second and third trimesters, on a schedule similar to traditional prenatal care. These sessions are conducted in a group and replace one-on-one prenatal visits with your provider. During each two-hour session you will assess your health status by taking your weight and vital signs, have a health assessment by the provider (a Certified Nurse Midwife or Nurse Practitioner), and participate in a group discussion of pertinent prenatal issues. Attendance at every session is a requirement for participation in the program (an exception will be made for emergencies). One support person is welcome to attend sessions with you.

Sessions are conducted in a conference room, not an examination room, with a relaxed and comfortable atmosphere. You will get to spend two hours with a provider instead of the usual 15 minutes, so those questions that you forget to ask are a thing of the past! Sessions begin and end ON TIME, so no more delays to your schedule, AND you will know when all your appointments are ahead of time. If an issue arises that requires a private examination, every attempt to accommodate you THAT DAY will be made.

Enrollment occurs at or after your OB PE appointment. Please let your provider know at your OB PE appointment if you would like to enroll.

We are very excited to bring this wonderful program to our patients, and hope that you will continue to consider Centering Pregnancy for you and your family.

Please feel free to contact me if you have any questions or concerns about the Centering Pregnancy Program. Hope to see you soon!

Aloha,

Centering Pregnancy Coordinator
TAMC OB/GYN Outpatient Clinic

808.433.4593

TAMC'S Centering Pregnancy Program

OB REG NURSES: PLEASE FORWARD THIS INFORMATION TO THE CENTERING COORDINATOR AT TAMC OB/GYN CLINIC

PLEASE PRINT LEGIBLY.

Patient's Name: 0 _____

Spouse's/Support Person's Name: _____

Patient's DOD ID#: _____

Patient's FMP/Last 4 of Sponsor's SSN: _____

Is this your first baby? (please circle) ☐ Yes ☐ No

Daytime Phone Number: _____

Please allow us to contact you by email. Your email address will be used by the Centering Coordinator to communicate information regarding sessions, deliver letters from the Centering Coordinator, and to contact you regarding last minute changes to sessions in case you cannot be reached by phone.

EmailAddress: _____

Due Date (EDC or EDD): _____

OB PE APPT Date & Time: _____

OBPE Provider: _____

Patient's Name_____ **DoD ID #:**_____

EDINBURGH PERINATAL DEPRESSION SCALE (EPDS)

INSTRUCTIONS:
Please mark one box for each question that is the closest to how you have felt in the **PAST SEVEN 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 as 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 at all
   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

ATTENTION: If you have had ANY thoughts of harming yourself, please tell your Provider today.

Comments:_____

_____

* Murray and Cox 1990 * Cox, Holden & Sagovsky 1987 (TAMC OB/GYN FEB12)

TOTAL SCORE: 0 /30