MATERNAL MOOD SCREENER – Version A

	A	1	B	C	2
Now I am going to ask you about your mood in your lifetime and in the last two weeks. I will ask you "In your lifetime, have you ever had two weeks or more during which you felt like this?" You will answer with the words "Yes" or "No" or if you need a statement repeated, please let me know.	In your lifetime, have you ever had two weeks or more during which you: **If yes to Part A go to Part B**	**Criteria for Lifetime MDE** **If yes to any section in *A* mark ✧**	Have you had these problems nearly every day in the past two weeks? **If yes to Part B ask C**	Is this only due to the pregnancy?	**Criteria for Current MDE** **If yes to any section in *B* and not due to pregnancy mark ❍**
1. Felt sad, blue, depressed most of the day nearly every day?	❐ No ❐ Yes	✧	❐ No ❐ Yes		❍
2. Lost all interest and pleasure in things you usually cared about or enjoyed?	❐ No ❐ Yes	✧	❐ No ❐ Yes		❍
3(a). Lost or gained your appetite?	❐ No ❐ Yes	✧	❐ No ❐ Yes	❐ Yes ❐ No	❍
3(b). Lost weight without trying to – as much as two pounds a week for several weeks (or as much as 10 pounds altogether)?	❐ No ❐ Yes		❐ No ❐ Yes	❐ Yes ❐ No	
3(c). Gained weight without trying to – as much as two pounds a week for several weeks (or as much as 10 pounds altogether)?	❐ No ❐ Yes		❐ No ❐ Yes	❐ Yes ❐ No	
4(a). Had trouble falling asleep, staying asleep, or waking up too early?	❐ No ❐ Yes	✧	❐ No ❐ Yes	❐ Yes ❐ No	❍
4(b). Were sleeping too much?	❐ No ❐ Yes		❐ No ❐ Yes	❐ Yes ❐ No	
5(a). Talked or moved more slowly than is normal for you?	❐ No ❐ Yes	✧	❐ No ❐ Yes	❐ Yes ❐ No	❍
5(b). Had to be moving all the time, that is, couldn't sit still, paced up and down?	❐ No ❐ Yes		❐ No ❐ Yes	❐ Yes ❐ No	
6. Felt tired or without energy all the time?	❐ No ❐ Yes	✧	❐ No ❐ Yes	❐ Yes ❐ No	❍
7. Felt worthless, sinful, or guilty?	❐ No ❐ Yes	✧	❐ No ❐ Yes		❍

MATERNAL MOOD SCREENER – Version A (cont.)

	A	1	B	C	2
	In your lifetime, have you ever had two weeks or more during which you: **If yes to Part A go to Part B**	**Criteria for Lifetime MDE** **If yes to any section in *A* mark ✧**	Have you had these problems nearly every day in the past two weeks? **If yes to Part B ask C**	Is this only due to the pregnancy?	**Criteria for Current MDE** **If yes to any section in *B* and not due to pregnancy mark ❍**
8(a). Had a lot more trouble concentrating or making decisions than is normal for you?	❒ No ❒ Yes	✧	❒ No ❒ Yes	❒ Yes ❒ No	❍
8(b). Your thoughts came much slower than usual or seemed mixed up?	❒ No ❒ Yes		❒ No ❒ Yes	❒ Yes ❒ No	
9(a). Thought a lot about death – either your own, someone else's, or death in general?	❒ No ❒ Yes	✧	❒ No ❒ Yes		❍
9(b). Wanted to die?	❒ No ❒ Yes		❒ No ❒ Yes		
9(c). Felt so low you thought about committing suicide?	❒ No ❒ Yes		❒ No ❒ Yes		
(Ask questions as follows) 9(d). Have you ever attempted suicide? If yes, in the past two weeks have you attempted suicide?	❒ No ❒ Yes		❒ No ❒ Yes		
(Ask only if endorses 2 or more problems) 10. Did several of these problems happen at the same time?	❒ No ❒ Yes				
11. Did these problems interfere with your life or activities a lot?	❒ No ❒ Yes →		❒ No ❒ Yes		
Enter the number of boxes checked in each column.		# ✧ *marked* ______			# ❍ *marked* ______