

Post Partum Form

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

Date Of Last Pap Smear: _____ Delivering Doctor(s): _____

Date Of Delivery: _____ Please list any medications you are using: _____

Weeks Gestation At Delivery: _____ _____

Tell us about your delivery.

- | | | |
|---|--|---|
| <input type="checkbox"/> Vaginal | <input type="checkbox"/> Primary C-Section | <input type="checkbox"/> Repeat C-Section |
| <input type="checkbox"/> Forceps | <input type="checkbox"/> Breech | |
| <input type="checkbox"/> Vacuum | <input type="checkbox"/> Failure to progress | |
| <input type="checkbox"/> Episiotomy | <input type="checkbox"/> Fetal Distress | |
| <input type="checkbox"/> Laceration | <input type="checkbox"/> Malpresentation | |
| <input type="checkbox"/> Complications? | <input type="checkbox"/> Abrupton | |
| _____ | <input type="checkbox"/> Umbilical Cord Prolapse | |
| _____ | <input type="checkbox"/> Other: _____ | |

How many babies: _____

- Breast Feeding
- Bottle Feeding
- Both

Baby's Name: _____

Baby's Weight: _____

Baby's Gender: _____

Intercourse since delivery?

If yes:

With protection?

Yes No

What would you like
to use for birth
control?
(check one)

- Birth Control Pill
- Nuvaring
- IUD
- Condoms
- Tubal
- Vasectomy
- Unsure
- Other: _____

Any postpartum depression?

Yes No