

Name:

ID #:

Label



Human Services

# POST PARTUM EXAM

Women's Health Clinic

Date		Age		HT _____ WT _____ BP _____ T/P/R _____		
Allergies		MVI <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Counseled		BMI _____ Goal (BMI 19-24) _____ <input type="checkbox"/> Counseled		
Medications		MVI <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Counseled		Last Pregnancy WT _____		
Obstetrical History	GRAV	TERM	PRET	TAB	SAB	LIIVING
Prenatal Problems	Physical Exam		Marked=done		Blank-not done	
<input type="checkbox"/> Clinic G <input type="checkbox"/> SRC	Breast		Normal	Abnormal		
<input type="checkbox"/> ERC <input type="checkbox"/> NRC	Abdomen		<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> HROB	Ext. Genitalia		<input type="checkbox"/>	<input type="checkbox"/>		
Delivery Problems	Vagina		<input type="checkbox"/>	<input type="checkbox"/>		
Vaginal: <input type="checkbox"/> NSVD <input type="checkbox"/> vacuum <input type="checkbox"/> foreceps <input type="checkbox"/> episiotomy	Cervix		<input type="checkbox"/>	<input type="checkbox"/>		
Cesarean: <input type="checkbox"/> repeat <input type="checkbox"/> primary, reason _____	Uterus		<input type="checkbox"/>	<input type="checkbox"/>		
Delivery Date	Adnexa		<input type="checkbox"/>	<input type="checkbox"/>		
Bleeding Duration / LMP	Rectum		<input type="checkbox"/>	<input type="checkbox"/>		
Baby's weight _____ lbs. _____ oz. <input type="checkbox"/> male <input type="checkbox"/> female	Thyroid		<input type="checkbox"/>	<input type="checkbox"/>		
Neonatal Problems	Heart		<input type="checkbox"/>	<input type="checkbox"/>		
Feeding: <input type="checkbox"/> bottle _____ % <input type="checkbox"/> breast _____ %	Lungs		<input type="checkbox"/>	<input type="checkbox"/>		
Breastfeeding/Breast Problem	Extremities		<input type="checkbox"/>	<input type="checkbox"/>		
Work / Note needed?	HEENT / Fundi		<input type="checkbox"/>	<input type="checkbox"/>		
Sexually Active <input type="checkbox"/> No <input type="checkbox"/> Yes: <input type="checkbox"/> protected <input type="checkbox"/> unprotected	Neurologic		<input type="checkbox"/>	<input type="checkbox"/>		
Current Contraceptive Method <input type="checkbox"/> Counseled 18 months	Skin / Lymph nodes		<input type="checkbox"/>	<input type="checkbox"/>		
Contraceptive Desired	Other		<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Vaginal discharge / pain / itch <input type="checkbox"/> UTI Sx <input type="checkbox"/> Abd pain	LAB: Hgb _____		Accucheck _____			
<input type="checkbox"/> Constipation <input type="checkbox"/> Rectal pain / bleeding <input type="checkbox"/> None	UC	Done <input type="checkbox"/>	Not Done <input type="checkbox"/>	UA _____		
<input type="checkbox"/> Other:	GC	Done <input type="checkbox"/>	Not Done <input type="checkbox"/>	Preg Test _____		
Depression/Severe anxiety	Chlamydia	Done <input type="checkbox"/>	Not Done <input type="checkbox"/>	Wet Prep _____		
Abuse phys / sexual / emotion	Pap	Done <input type="checkbox"/>	Not Done <input type="checkbox"/>	Hemocult _____		
Smoking / Second hand	Assessment	1. Post Partum exam				
ETOH		2. Contraceptive counseling				
Illicit Drugs	Plan:					
Td / Tdap	Supplies					
Hepatitis A and B / TwinRix	Patient Education					
Gardasil / Menactra	Referrals					
Varicella disease / Vaccine	Next Appt/Annual Due					
Rubella	Signature _____	Signature _____				
Abnl Pap Hx / colpo / Tx	Interpreter:					
Date / Result last 3 Paps						
FP Counseling / Consent / Infection / ER instructions / Calcium / Exercise						