



**Women Partners**  
in OB/GYN

Postpartum Update Form

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Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Doctor: \_\_\_\_\_

**Delivery Information:**

Delivery Date: \_\_\_\_\_

Type of Delivery:  Vaginal  C-Section

During your pregnancy, did you have any of the following:

Gestational diabetes  Elevated blood pressure  Preterm delivery

Other pregnancy or delivery complications: \_\_\_\_\_

**Postpartum Information:**

Do you have any vaginal bleeding concerns today: \_\_\_\_\_

Describe any pain you are currently having: \_\_\_\_\_

If you had a C-Section, do you have any concerns about your incision? \_\_\_\_\_

How do you plan to prevent pregnancy? \_\_\_\_\_

Do you have any concerns about your mood since delivery? \_\_\_\_\_

**Infant Information:**

Infant health update: \_\_\_\_\_

How do you feed your baby?  Formula  Breastfeeding  Pumping  Combination

**Updates Since Delivery:**

Medication Changes: \_\_\_\_\_

Allergy Updates: \_\_\_\_\_

Medical/Surgical History Changes: \_\_\_\_\_

Social History Changes (marital status, job, school, family, stressors etc): \_\_\_\_\_

Abuse Screen:  None  Physical abuse  Sexual abuse  Emotional abuse

(Continued on back)

**Review of Systems:**

(Please check all that apply to you **TODAY**)

	Yes		Yes
<b>Gynecological</b>		<b>Genitourinary</b>	
Vaginal discharge/irritation/odor		Painful urination	
Irregular bleeding		Leaking urine	
Painful periods		Urinary urgency	
Painful intercourse		Urinary frequency	
Pelvic pain		Blood in urine	
Genital sores/bumps		Nocturia (urinating 2 or more times/night)	
Sexual function concerns			
		<b>Psychological</b>	
<b>Breasts</b>		Anxiety	
Breast lump		Depression	
Nipple discharge		Difficulty sleeping	
Breast pain		Panic attacks	
<b>Gastrointestinal</b>		<b>Constitutional</b>	
Abdominal pain		Headache	
Nausea		Fatigue	
Vomiting		Fever/chills	
Constipation		Weight gain	
Diarrhea		Weight loss	
Blood in stool			
Change in bowel habits		<b>Other Concerns:</b>	

**Office Use:**

Last pap smear date/result: \_\_\_\_\_

PHQ-9 score: \_\_\_\_\_ GAD – 7 score: \_\_\_\_\_

Contraception plan: \_\_\_\_\_

Follow up/labs for GDM, CHTN, etc.: \_\_\_\_\_

\_\_\_\_\_