BlueCross BlueShield of Texas

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Postpartum Checkup Form

Name: _____ Date of Birth: _____ Date of Office Visit: _____

Language Spoken: _____ Interpreter Name: _____

Nursing Intake

Height: _____ Weight: _____ BMI: _____

BP: _____ Temperature: _____ Pulse: _____ Respiration: _____

Allergies: _____

Last PAP Smear date: _____ Results: _____

Birth History

G: _____ P: _____ Ab: _____ LMP: _____

Delivery Date: _____

Delivery Method: ☐ NSVD ☐ C-Section

Complications: _____ ☐ None

Spinal/epidural headaches: ☐ Yes ☐ No

Infant Information

Sex: ☐ Male ☐ Female Birth weight: _____

Breastfeeding: ☐ Yes ☐ No Formula feeding: ☐ Yes ☐ No

Delivery Hospital: _____

Complications or problems: _____ ☐ None

Pediatrician: _____

Is mother getting enough sleep: ☐ Yes ☐ No

Birth Control

☐ OCP ☐ BTL ☐ Depo ☐ Patch ☐ IUD ☐ Condoms ☐ Foam ☐ Other

Has mother resumed sexual activities? ☐ Yes ☐ No Does mother feel depressed? ☐ Always ☐ Sometimes ☐ Never

Rubella Status: _____

Mother's Concerns (please document): _____

Physical Examination (check all that apply):

General appearance	☐ Well nourished and developed	Pelvic	☐ Perineum – Well healed, intact no lesions
	☐ No abuse/neglect evident		☐ Uterus –Firm, nontender, small
Breast	☐ Lactating ☐ Nonlactating		☐ Adnexa – No masses
Abdomen	☐ Soft, nontender ☐ Incision healing normal		☐ Vagina - Intact
Skin	☐ Clear, no significant lesions		☐ Cervix - Intact

Assessment

Plan

Stop Smoking

☐ Advise smoker to quit ☐ Discuss smoking cessation medication ☐ Discuss smoking cessation strategies

Referrals

☐ Pap ☐ UA: _____

☐ Hgb ☐ Rx for folic acid .4 mg qd (if another birth anticipated) ☐ Colposcopy

☐ MMR to be given or rubella titer ordered with vaccine reactions, risk and follow-up explained/VIS sheet given: _____

Anticipatory Guidance (check if discussed):

☐ Obesity, eating disorders, eating habits, diets ☐ Risk: abuse, drug use, sexual education

☐ Breast self-exam, breastfeeding, formula feeding ☐ Given health education material on: _____

Referral ☐ Yes ☐ No Referral to: _____

☐ Next appointment 1 or 2 or 3 years for physical or: _____

Signature: _____ Date: _____

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