

Brunswick-Hills OB/GYN

POST PARTUM HISTORY

Patient ID # _____

Date of visit _____

Name _____ Age _____ Date of Birth _____

REASON FOR VISIT _____

ALLERGIES _____

ALL MEDICATIONS (dose & frequency) _____

DELIVERY INFORMATION

Of Pregnancies _____ #Of Living Children _____ #Of Boys _____ #Of Girls _____

DELIVERY: VAGINAL CESAREAN (primary / repeat)
 VACUUM FORCEPS EPISIOTOMY TEAR

COMPLICATIONS: _____

HOSPITAL BABY WAS DELIVERED: _____

DOCTOR/MIDWIFE DELIVERED: _____

BABY'S GENDER: MALE / FEMALE TWINS WEIGHT _____

BABY'S NAME: _____ DURATION OF LABOR _____

DATE OF DELIVERY: _____ METHOD OF FEEDING: _____

GYN HISTORY Blood type _____ Last Menstrual Period _____

Contraception: past _____

DATE and Result of last Pap Smear: _____

SURGERY HISTORY _____ None

Procedure	Year	Complications
_____	_____	_____
_____	_____	_____
_____	_____	_____

DO NOT WRITE BELOW HERE:

WT _____

HT _____

BP _____

LMP _____

RUBELLA _____

Patient requests an assistant in room

Patient initials: YES ___ NO ___

Assistant initials _____