Supplemental Postpartum Intake

Name: _____ Date: _____

Delivery date: _____ How many weeks postpartum? _____

Obstetrician/Midwife name: _____

What hospital did you deliver at?: _____

Describe delivery (including epidural, induction, any problems or concerns, blood pressure, episiotomy, OP/sunny-side up, back labor etc.)

Length of Labor: _____

Length of Active Labor (time pushing): _____

Tearing? What degree of tear?: _____

Any complications? Y/N Describe: _____

Are you currently breastfeeding? Y/N

Are you still bleeding? Y/N

Placenta retention? Y/N

Are you experiencing fever or chills? Y/N

Any stress incontinence (urination on sneezing, coughing, jumping, etc.) since delivery? Y/N Describe:

_____

_____

Describe major postpartum complaint:

_____
_____
_____
_____