Stanford HEALTH CARE

Post-partum Visit

Name: _____ Pregnancies: _____ Children: _____ Date: _____

Date of delivery: _____ Baby's name: _____ Gender: M F

Baby weight at delivery: _____ ❑ Vaginal delivery ❑ Cesarean section ❑ VBAC

Delivering doctor: _____ Epidural ❑ Natural ❑ Spinal ❑

Complications with pregnancy or delivery: _____

Complications with baby: _____

Problems since delivery: _____

Preferred method of birth control: ❑ None ❑ Rhythm ❑ Condoms ❑ Birth control pills ❑ Patch ❑ Nuvaring ❑ Diaphragm ❑ Mirena IUD ❑ Paragard IUD ❑ Depo-provera ❑ Nexplanon

Breast feeding: ❑ Yes ❑ No Post-partum depression - see back page to complete questionnaire

Please list any questions, symptoms, concerns or anything else that you would like to discuss:

Please check any of the following that you are currently experiencing: ❑ **NONE**

General: ❑ Extreme fatigue ❑ Depression ❑ Fever

Weight change, how much? _____ ❑ Skin: Change in mole ❑ Rash

Respiratory-Cardiac: ❑ Shortness of breath ❑ Cough ❑ Chest pain ❑ Palpitations

Breast: ❑ Lump ❑ Nipple discharge ❑ Redness of breast

Gastrointestinal: ❑ Abdominal pain ❑ Blood in stools ❑ Bloating ❑ Diarrhea ❑ Constipation ❑ Hepatitis or exposure to hepatitis ❑ Change in bowel movements

Gynecologic: ❑ Heavy periods ❑ Severe pain with periods ❑ Vaginal dryness ❑ Pain with sex

Urinary: ❑ Incontinence ❑ Frequent bladder infections ❑ Blood in urine

Musculoskeletal: ❑ Muscle aches ❑ Weakness

Neurologic: ❑ Change in headaches ❑ Numbness ❑ Dizziness

For Nursing and Doctors:

Weight _____ B/P _____ Score from PHQ-9 _____ ❑ IUD today ❑ OCP pdg

Please complete the back page

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Patient Health Questionnaire (PHQ-9)

Patient Name: _____ **Date:** _____

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not At All	Several Days	More Than Half the Days	Nearly Every Day
a. Little interest or pleasure in doing things	❑	❑	❑	❑
b. Feeling down, depressed, or hopeless	❑	❑	❑	❑
c. Trouble falling/staying asleep, sleeping too much	❑	❑	❑	❑
d. Feeling tired or having little energy	❑	❑	❑	❑
e. Poor appetite or overeating	❑	❑	❑	❑
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	❑	❑	❑	❑
g. Trouble concentrating on things, such as reading the newspaper or watching television	❑	❑	❑	❑
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual	❑	❑	❑	❑
i. Thoughts that you would be better off dead or of hurting yourself in some way	❑	❑	❑	❑
2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	**Not Difficult at all** ❑	**Somewhat Difficult** ❑	**Very Difficult** ❑	**Extremely Difficult** ❑