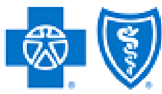

BlueCross BlueShield of Texas

Blue Cross and Blue Shield of Texas

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
☐ No abuse/neglect evident

Breast ☐ Lactating ☐ Nonlactating

Abdomen ☐ Soft, nontender ☐ Incision healing normal

Skin ☐ Clear, no significant lesions

Pelvic ☐ Perineum – Well healed, intact no lesions
☐ Uterus –Firm, nontender, small
☐ Adnexa – No masses
☐ Vagina - Intact
☐ 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

☐ Breast self-exam, breastfeeding, formula feeding

Referral ☐ Yes ☐ No

☐ Risk: abuse, drug use, sexual education

☐ Given health education material on: ____________

Referral to: ____________

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

Signature: ____________ Date: ____________