

POST PARTUM PROGRESS NOTE

Date: _____ Name: _____ DOB: _____

Date of Delivery: _____ Vaginal C/S Breast Bottle

Infant Name: _____ Infant's MD _____ Date Seen: _____

Adjustment to infant by mom: _____ by partner _____ by siblings _____

BP _____ Weight: _____ Contraceptive Plans: _____

Assessed/Discussed:

- Return of menses Date: _____
- Post Partum depression Support Structure Preconception Counseling
- Smoking cessation Alcohol/drug use Weight
- HIV/STD Risk Reduction Issues (Not sexually active; Monogamous ; Condom Use)

Exam	NL	ABN	Comments
HEENT			
Heart			
Lungs			
Breasts (pain, drainage, etc)			
Abdomen			
Extremities			
Lymph			
Thyroid/neck			

Pelvic Exam	NL	ABN	Comments
Vulva			
Vagina			
Cervix			
Uterus			
Adnexa			
Rectum			
Introitus			
Lochia/vaginal discharge			

Assessment/Plan: _____

MD Signature: _____ Copy to PCP - MD Initials: _____