

### Post-Partum Visit

Please complete the following:

**Date of delivery:** \_\_\_\_\_

**Type of Delivery:**  Vaginal  Cesarean  
 VBAC

**Baby's Name :** \_\_\_\_\_ **Gender**  M  F **Birth Weight:** \_\_\_\_\_ lbs \_\_\_\_\_ oz

Add this information here for a twin baby:

**Delivery Anesthesia:**  Epidural  Natural  Spinal

**Delivering Doctor:** \_\_\_\_\_

**Complications with delivery:** \_\_\_\_\_

**Was your baby born with any complication and/or admitted to the NICU?**  No  Yes (please explain:)  
\_\_\_\_\_

**Are you:**  breastfeeding  formula feeding  both

**Please list any questions or problems you would like to discuss:**

**What method of birth control would you like to use?**

- None
- Birth control pills
- IUD (Mirena, Skyla, Kyleena)
- Condoms
- Patch
- IUD (Paragard)
- Depo Provera (injection)
- Nuvaring
- Nexplanon
- Vasectomy for partner
- Tubal sterilization done
- Unknown

**Do you need information for support services (lactation, WIC)?**  Yes  No  N/A

Clinic Use Only: Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_/\_\_\_\_\_ PHQ9 Score \_\_\_\_\_

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Please ○ (CIRCLE) the box with your response

	Not at all	Several days	More than half the days	Nearly every day
a. little interest or pleasure in doing things.	0	1	2	3
b. feeling down, depressed or hopeless.	0	1	2	3
c. trouble falling or staying asleep or sleeping too much.	0	1	2	3
d. feeling tired or having little energy.	0	1	2	3
e. poor appetite or overeating.	0	1	2	3
f. feeling bad about yourself or that you are a failure or have let yourself or your family down.	0	1	2	3
g. trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
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.	0	1	2	3
i. thoughts that you would be better off dead or of hurting yourself in some way.	0	1	2	3

ADD COLUMNS

\_\_\_\_\_ + \_\_\_\_\_ + \_\_\_\_\_

TOTAL \_\_\_\_\_

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

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