Dedicated to Women | OB/GYN

Postpartum Questionnaire

1. Do you have any specific concerns you would like to address at this visit?
2. Are you: Breastfeeding? Bottle feeding? Both?
3. Do you have concerns or questions about breastfeeding?
4. What are you planning on using for contraception?
   Please Circle Below

   Condoms, spermicide
   Birth Control Pill
   Birth Control Patch
   Birth Control Ring (Nuvaring)
   Natural Methods
   IUD (Mirena, Skyla, Liletta, Paragard)
   Implant (Nexplanon)
   Shot (Depo-Provera)
   Permanent surgical sterilization (Tubal Ligation)

5. Are you concerned you may have postpartum depression/anxiety? Yes or No
   if you answered yes, please fill out the depression questionnaire attached.
6. Have you had sex yet? Yes or No
   If so was it painful? Yes or No
   Did you use any contraception? Yes or No Protected? or Unprotected?
7. How much sleep are you getting in 24 hrs? _____
8. Do you feel rested? Yes or No
9. Are you still having vaginal bleeding or discharge? Yes or No
10. Do you have any rectal or urinary incontinence (inability to hold in urine, gas or bowel movements)? Yes or No
11. Do you have any questions about your Birth Experience?

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