RWJ OB/GYN associates

Post Partum Exam

Pt Name:_____ **G**_____**P**_____
Delivered by:_____ **Blood Type**:_____
Delivery Date:_____ **Breast Feeding?**: **Y** **N**
Type:_____ **Gender**:_____ **Birth Control Desired?**: **Y** **N**
Baby Wt: ___**lbs** ___**oz** **Apgars**:_____
Baby Name:_____

❖ Incision Check/Staple Removal

DATE:_____ **BP**:_____**/**_____ **Weight:**_____ **lbs**

Abdomen: _____

Incision:_____ **Testing Ordered:**_____

❖ Post Partum Exam

DATE:_____ **BP**:_____**/**_____ **Weight:**_____ **lbs**

Breast: _____ **Cervix**:_____

Abdomen:_____ **Uterus**:_____

Ext. Genitalia:_____ **Adnexae**:_____

Vagina:_____ **Rectal**:_____

Other:_____

• **PAP Smear Today** **YES** **NO** **Last PAP (Date/Result)**:_____

Rx:_____

Testing Ordered:_____

Signature:_____ **RR RB JL JS AH EK** **Date**:_____