Sample Postpartum Follow-up Checklist

To help us better care for you, please complete this survey and return it to us at your visit. Our discussions with you are private. Your information will not be shared with other people without permission unless we are concerned that someone is in danger.

Thank you for your time.

Note to Providers: In order to facilitate conversations about the many issues that affect maternal health and wellbeing in the early postpartum period, the Task Force drafted a checklist for women to complete at postpartum clinic encounters. This checklist is a framework that has not been tested in clinical care; therefore, health care providers are encouraged to modify for their clinical context.

NAME [Patient Name]	DOB	DATE OF DELIVERY
_____	_____	[date | time]

What Would You Like to Talk About at Your Visit?

- Do you have any concerns, questions, or problems that you would like to discuss at your visit?

  [Comments] _____

  _____

- What changes or challenges have there been at home since you gave birth?

  [Comments] _____

  _____

- Have you called the office, visited the emergency room, or called your primary care provider for a problem or issue since you gave birth? If so, for what reason?

  [Comments] _____

  _____

- Are you currently taking any medications? (prescribed, over-the counter, or herbal therapies)

  [Comments] _____

  _____

Postpartum Checklist

We are interested in answering your questions.
Please check off the box for the main topics you would like to discuss at **today's visit**

Infant feeding	❑ Infant feeding is going well, but I still have questions ❑ I have pain with breastfeeding ❑ I am having difficulty breastfeeding my infant ❑ I am worried that I will not be able to meet my breastfeeding goals ❑ I have concerns about going back to work or school and maintaining my milk supply
Bleeding	❑ My bleeding has decreased in amount since the birth of my infant ❑ I am concerned about the amount, color, odor of my bleeding
Bladder	❑ I am having pain while emptying my bladder ❑ I have difficulty emptying my bladder ❑ I have a hard time controlling my bladder (I leak or do not make it to the restroom) ❑ I do not have any issues with my bladder
Bowels	❑ I am having pain while using the toilet to pass stool ❑ I have difficulty moving my bowels (I am feeling constipated) ❑ I have a hard time controlling my bowels (My stool leaks) ❑ I am not having any issues
Incision or laceration	❑ My incision or laceration has been healing well; it does not bother me ❑ I am concerned that my incision/laceration is not healing well
Other symptoms	I am feeling the following symptoms: ❑ Lightheaded ❑ Shortness of breath ❑ Chest pain ❑ Heart racing ❑ Headache ❑ Blurry vison ❑ I am not feeling any symptoms
Safety	❑ I am concerned about keeping myself and my family safe ❑ I am not concerned about keeping myself and my family safe
Nutrition and exercise	❑ I would like to learn more about eating healthy and incorporating exercise into my daily life
Emotions and well-being*	In the past 7 days, I have felt ❑ anxious or worried for no good reason ❑ scared or panicky for no very good reason I have been so unhappy that I have ❑ had difficulty sleeping ❑ been sad or miserable ❑ been crying ❑ had thoughts of harming myself

Emotions and well-being*	❑ I would like to discuss support groups/counseling services available in my area _____
Family planning and contraception	❑ I would like to be pregnant in the next year ❑ I want to prevent pregnancy and discuss my options for birth control ❑ I want to obtain a form of birth control at my visit
Sexuality	❑ I am interested in having sex and so is my partner. I still have questions ❑ I am interested in having sex but my partner is not interested. ❑ I am not interested in having sex but my partner is. ❑ I am concerned about having sex again after having my infant. ❑ I am not sexually active
Smoking	❑ I want to decrease/stop smoking ❑ I am concerned about myself and my infant being exposed to other family members who smoke. ❑ I do not smoke and I am not concerned about myself or my infant being exposed to other family members who smoke.
Alcohol and other drugs	❑ I would like to decrease the amount of alcohol I use and need help. ❑ I need help with my drug use. ❑ I do not have an alcohol or drug problem.
Infant care	❑ Caring for my infant is going well but I still have questions. ❑ I am having difficulty caring for my infant
Sleep and rest	❑ I am not getting adequate sleep and rest. ❑ I am getting adequate sleep and rest.
Support	❑ I have enough or some support at home, but would like more help. ❑ I do not have enough support at home.
Resources	I need help with signing up for ❑ Insurance ❑ Women, Infants, and Children (WIC) program I do not have enough ❑ food ❑ diapers ❑ clothes ❑ I do not have access to clean water. ❑ I do not have heat or air conditioning in my house. ❑ I need help with housing.
Other questions and concerns	❑ I have other questions and concerns for this visit related to: _____

*In addition to the checklist, we recommend that patients be screened for postpartum depression using a validated instrument, such as the EPDS or the PHQ9.

For health care providers: If you use the checklist in your clinical setting, please share your experience with us at postpartum@acog.org, so that we can incorporate your feedback into revised versions.