

Post Partum Exam

Name: _____ Date: _____

Date of Delivery: _____

Type of Delivery? Vaginal or C-Section

Physician that delivered your baby? _____

Did you have an epidural? Yes or No

Did you have any complications?

Name of baby: _____

Sex of baby: Male or Female

Are you breast feeding or pumping milk? Yes or No

How long are you planning to breast feed/pump? _____

Are you having any of the following problems?

Bleeding Problems Yes or No

GI problems Yes or No

Urinary Complaints Yes or No

Pain Problems Yes or No

Mood or Depression Problems Yes or No

What have you previously used for birth control? _____

OFFICE USE ONLY

Weight _____ BP _____ Hgb _____ U/A _____



Edinburgh Perinatal/Postnatal Depression Scale (EPDS)

For use between **28–32 weeks** in **all** pregnancies and **6–8 weeks** postpartum

Name: _____ Date: _____ Gestation in Weeks: _____

As you are having a baby, we would like to know how you are feeling. Please mark “X” in the box next to the answer which comes closest to how you have felt in the **past 7 days**—not just how you feel today.

In the past 7 days:

- | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>1. I have been able to laugh and see the funny side of things</p> <p>0 <input type="checkbox"/> As much as I always could</p> <p>1 <input type="checkbox"/> Not quite so much now</p> <p>2 <input type="checkbox"/> Definitely not so much now</p> <p>3 <input type="checkbox"/> Not at all</p> | <p>6. Things have been getting on top of me</p> <p>3 <input type="checkbox"/> Yes, most of the time I haven't been able to cope</p> <p>2 <input type="checkbox"/> Yes, sometimes I haven't been coping as well as usual</p> <p>1 <input type="checkbox"/> No, most of the time I have coped quite well</p> <p>0 <input type="checkbox"/> No, I have been coping as well as ever</p> |
| <p>2. I have looked forward with enjoyment to things</p> <p>0 <input type="checkbox"/> As much as I ever did</p> <p>1 <input type="checkbox"/> Rather less than I used to</p> <p>2 <input type="checkbox"/> Definitely less than I used to</p> <p>3 <input type="checkbox"/> Hardly at all</p> | <p>7. I have been so unhappy that I have had difficulty sleeping</p> <p>3 <input type="checkbox"/> Yes, most of the time</p> <p>2 <input type="checkbox"/> Yes, sometimes</p> <p>1 <input type="checkbox"/> Not very often</p> <p>0 <input type="checkbox"/> No, not at all</p> |
| <p>3. I have blamed myself unnecessarily when things went wrong</p> <p>3 <input type="checkbox"/> Yes, most of the time</p> <p>2 <input type="checkbox"/> Yes, some of the time</p> <p>1 <input type="checkbox"/> Not very often</p> <p>0 <input type="checkbox"/> No, never</p> | <p>8. I have felt sad or miserable</p> <p>3 <input type="checkbox"/> Yes, most of the time</p> <p>2 <input type="checkbox"/> Yes, quite often</p> <p>1 <input type="checkbox"/> Not very often</p> <p>0 <input type="checkbox"/> No, not at all</p> |
| <p>4. I have been anxious or worried for no good reason</p> <p>0 <input type="checkbox"/> No, not at all</p> <p>1 <input type="checkbox"/> Hardly ever</p> <p>2 <input type="checkbox"/> Yes, sometimes</p> <p>3 <input type="checkbox"/> Yes, very often</p> | <p>9. I have been so unhappy that I have been crying</p> <p>3 <input type="checkbox"/> Yes, most of the time</p> <p>2 <input type="checkbox"/> Yes, quite often</p> <p>1 <input type="checkbox"/> Only occasionally</p> <p>0 <input type="checkbox"/> No, never</p> |
| <p>5. I have felt scared or panicky for no very good reason</p> <p>3 <input type="checkbox"/> Yes, quite a lot</p> <p>2 <input type="checkbox"/> Yes, sometimes</p> <p>1 <input type="checkbox"/> No, not much</p> <p>0 <input type="checkbox"/> No, not at all</p> | <p>10. The thought of harming myself has occurred to me</p> <p>3 <input type="checkbox"/> Yes, quite often</p> <p>2 <input type="checkbox"/> Sometimes</p> <p>1 <input type="checkbox"/> Hardly ever</p> <p>0 <input type="checkbox"/> Never</p> |

Total Score

Talk about your answers to the above questions with your health care provider.

Translations for care-provider use available on PSBC website: perinatalservicesbc.ca.