INLAND EMPIRE HEALTH PLAN
COMBINED POST-PARTUM ASSESSMENT

Member Name_____ DOB_____ Delivery Date _____Date_____

ANTHROPOMETRIC ☐ WT. GRID PLOTTED
Height _____ Desirable Body Weight_____
Weight this Visit _____ Weeks Post-Partum_____

BIOCHEMICAL
Blood Date Collected:
Hemoglobin: **H L** Hematocrit: **H L**
Glucose: **H L** Albumin: **H L**
Blood Pressure: / (circle) GDM PIH

CLINICAL - Outcome of Pregnancy
Date of Birth _____ Gestational Age _____
Birth Weight _____ Birth Length _____
Delivery: ☐ Vaginal ☐ C-section
Pregnancy Outcome/Complications:

Maternal
1. Have you had your post-partum check up? ☐ Y ☐ N
   If NO, when is it scheduled?
   _____
2. Have you had any problems since delivery: ☐ Y ☐ N
   If YES, please explain.

Infant
3. Has your baby seen the doctor? ☐ Y ☐ N
   If NO, when is a visit scheduled? _____

NUTRITION
Dietary Assessment ☐ 24 hour recall completed
4. Are you on a special diet? ☐ Y ☐ N
   If YES, what diet? _____
5. Are you allergic to any foods, or do you avoid eating any foods? ☐ Y ☐ N
   If YES, what foods?_____
6. Which of the following do you take:
   ☐ Prenatal Vitamins ☐ Iron Pills
   ☐ Other Vitamins/Minerals ☐ Herbs
   ☐ Antacids ☐ Laxatives ☐ Other Medications
7. How many cups, glasses, or cans of these do you drink daily? Water _____ Milk _____
   Juice _____ Coffee _____
   Tea _____ Soda _____
   Diet Soda _____ Punch/Kool Aid _____
8. How many times a day do you usually eat? _____
9. Which of the following do you have?
   ☐ Refrigerator ☐ Stove/Oven ☐ Hot Plate

Infant Feeding
10. How many diapers does your baby wet in a day? _____
11. If you are Breastfeeding:
    a) how many times in 24 hours do you nurse? _____
    b) how long does your baby nurse each time? _____

Infant Feeding (cont)
12. If you are Bottlefeeding,:
    a) how often does your baby get a bottle? _____
    b) how much does your baby drink at a feeding?_____
    c) ✓ the one(s) you use: ☐ Concentrated Formula
       ☐ Powdered Formula ☐ Ready to Drink Formula
    d) what else do you give your baby? ☐ Juice ☐ Cereal
       ☐ Sugar Water ☐ Baby Food ☐ Other _____

HEALTH EDUCATION
13) Do you have any questions about your baby's care? ☐ Y ☐ N
    If YES, please explain:
14) Which method of Birth Control are you currently using:
    ☐ Birth Control Pills ☐ Diaphragm ☐ Condoms
    ☐ Norplant ☐ Depo-Provera(shots) ☐ Other _____
15) Would you like more information about Birth Control?
16) Do you have an infant safety seat? ☐ Y ☐ N
    If YES, do you always use it?_____
17) Do you exercise 3 or more times a week? ☐ Y ☐ N
18) Do you smoke ? ☐ Y ☐ N
    If YES, how many cigarettes per day? _____
19) Do you live with someone who smokes?
20) How often do you drink beer, wine, or liquor? _____
21) What drugs have you used since the birth of your baby?

PSYCHOSOCIAL
22) Since your baby's birth, which of the following have you had?
    ☐ trouble sleeping ☐ sadness ☐ worried feelings
    ☐ crying ☐ depression ☐ sadness ☐ none
    ☐ other_____
23) If you are worried about something, who do you talk to?
    _____
24) Are you and your baby are safe in your home? ☐ Y ☐ N
25) Have you ever planned or tried to hurt yourself? ☐ Y ☐ N
26) Have you ever planned or tried to hurt someone? ☐ Y ☐ N
27) Since the birth of your baby, have you been slapped, hit, kicked or otherwise physically hurt by someone? ☐ Y ☐ N
    If YES, by whom? _____
28) Do you have: ☐ electricity ☐ hot water ☐ telephone
    ☐ transportation ☐ heating
29) Are you able to buy enough food? ☐ Y ☐ N
30) Are you able to pay your rent? ☐ Y ☐ N
31) Are you able to pay your other bills? ☐ Y ☐ N

☐ WIC Referral Date enrolled _____
Appointment Date _____
Other Referrals**:**
1) _____ Date _____
2) _____ Date _____
Materials Given**:**
☐ Family Planning ☐ Infant Feeding
☐ Other _____ ☐ Other _____

For Provider Use Only
Number:_____
Prenatal Care Provider:_____

IEHP Member

IEHP Provider Number:_____