OB Post Delivery Progress Record  
(Vaginal and C-Section)

* Indicates a REQUIRED field

[ ] I have reviewed home medications

* Delivering MD: ________________________________

* Assistants: (None Unless noted) ________________________________

* Post Op / Final Diagnosis: IUP (Intrauterine pregnancy) with

[ ] Full term infant (>37 wks) [ ] Preterm infant (<37 wks) [ ] Still born

Procedure Description:

* Delivery Type: Choose delivery type

Vaginal Delivery

[ ] SVD [ ] LF [ ] VAC [ ] VTX [ ] Breech (type) ________________________________

C-Section

[ ] LUT [ ] LUV [ ] Classical [ ] Repeat Elective [ ] Repeat Classical

Mode of Delivery Assist

[ ] Vacuum [ ] Forceps

* Findings (described below):

INFANT: [ ] Male [ ] Female [ ] Single [ ] Multiple

a) APGARS: ____________________________ / ____________________________ / 

Weight __ lbs __ oz. Grams: ____________________________

Fluid: [ ] CLEAR [ ] MEC: [ ] Thick [ ] Light

ABNORMALITIES (None unless noted):

[ ] Nuchal cord x [ ] True knot

PLACENTA: [ ] SPONTANEOUS [ ] MANUAL [ ] UTERUS EXPLORED

* EBL: ________________________________

* SPECIMENS TO PATHOLOGY: (None unless otherwise specified):

[ ] PLACENTA [ ] OTHER ________________________________

ANESTHESIA: [ ] NONE [ ] LOCAL [ ] PUDENDARAL [ ] EPIDURAL [ ] SPINAL

EPISIOTOMY: [ ] NONE [ ] MEDIAN [ ] MEDIOLATERAL: [ ] 1 [ ] 2 [ ] 3 [ ] 4

REPAIR: [ ] YES [ ] NO

Suture: ________________________________

LACERATION: [ ] NONE [ ] CERVICAL [ ] VAGINAL [ ] PERIURETHRAL

[ ] PERINEAL: [ ] 1 [ ] 2 [ ] 3 [ ] 4

REPAIR: [ ] YES [ ] NO

Suture: ________________________________

COMMENTS: ________________________________

CONDITIONS: [ ] STABLE [ ] OTHER (describe) ________________________________

Date _______ Time _______ Physician’s Signature _______ MD Number _______