Postpartum Pelvic Health Survey

Patient Name ____

Dr. ______________________________________ Date / /

Please complete and return this form to your physician:

What was the mode of your delivery: ☐ Vaginal ☐ Cesarean

Did you experience a vaginal tear or episiotomy? ☐ Yes ☐ No

Were forceps or a vacuum used? ☐ Yes ☐ No

Are you experiencing pelvic pain? ☐ Yes ☐ No

If you have resumed intercourse (sex), are you experiencing pain with intercourse? ☐ Yes ☐ No

Do you have a feeling of a “ball” in your vagina? ☐ Yes ☐ No

Are you having vaginal dryness? ☐ Yes ☐ No

Are you leaking urine? ☐ Yes ☐ No

Are you leaking stool? ☐ Yes ☐ No

Are you constipated? ☐ Yes ☐ No

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