ascension fitness
Taking Your Performance To New Heights

Postpartum Health Screen Questionnaire

Client Name	
Client Date of Birth	
Date of Last Delivery	

1. Type of Childbirth	Check One: ❑ C-Section ❑ Vaginal
2. If you had a vaginal delivery did it require assistance of forceps or vacuum?	Check One: ❑ Yes ❑ No
3. If C-section did you have any other procedures such as hysterectomy, tubes tied, or any plastic surgery?	Check One: ❑ Yes ❑ No
4. Were there any complications during your pregnancy? (preclampsia or toxemia, gestational diabetes, hypertension, pregnancy related liver disease, bleeding, or anything else not normal)?	Check One: ❑ Yes ❑ No
5. Were you ever put on bed rest during your pregnancy?	Check One: ❑ Yes ❑ No
6. If answered 'Yes' to Question 5, please explain why?	
7. Were there any complications after childbirth? (extensive vaginal or rectal repair after delivery, Blood clots, problems nursing, urinary incontinence, anal incontinence, prolapsed uterus, anything irregular with placenta detachment or anything else you don't feel was normal)	Check One: ❑ Yes ❑ No
8. If answered 'Yes' To Question 7, please the length of time the problem persisted?	
9. Are you nursing currently?	Check One: ❑ Yes ❑ No
10. If answered 'Yes' to Question 9, how long do you plan on nursing?	
11. If answered 'Yes' to Question 9, have you had any problems such as blocked ducts, mastitis, thrush, or anything else you feel is not normal?	Check One: ❑ Yes ❑ No

ascension fitness
Taking Your Performance To New Heights

Postpartum Health Screen Questionnaire

Client Name	

12. Did you exercise during your pregnancy?	Check One: ❑ Yes ❑ No
13. If you answered 'Yes' to Question 12, please explain what you did and how often.	
14. Did you exercise previous to becoming pregnant?	Check One: ❑ Yes ❑ No
15. If you answered 'Yes' to Question 14, please explain what you did and how often.	
16. Have you been cleared for exercise by your OBGYN?	Check One: ❑ Yes ❑ No
17. Who is your OBGYN/Doctor?	Name: Phone #:
18. Have you ever smoked?	Check One: ❑ Yes ❑ No
19. If you answered 'Yes' to Question 18, have you quit?	Check One: ❑ Yes ❑ No
20. If you answered 'Yes' to Question 19, on what date did you quit smoking?	
21. If you answered 'No' to Question 19, how many cigarettes do you smoke per day?	# of cigarettes per day
22. What exercises do you enjoy doing?	
23. What are your personal goals to accomplish in the next 8 weeks?	