

Facility Logo  
Facility Name  
Facility Address

**POSTPARTUM CARE RECORD**

**PART I. PATIENT (MOTHER) INFORMATION**

PhilHealth Accreditation Number (PAN) - Institutional Health Care Provider:  -  -

1. Health Facility Name: \_\_\_\_\_

2. Name of Patient: \_\_\_\_\_  
Last Name                      First Name                      Middle Name

3. PhilHealth Identification Number (PIN):  -  -

4. Address: \_\_\_\_\_  
House number/Street                      Subdivision/Barangay                      City/Municipality                      Province                      ZIP Code

5. G \_\_\_ P \_\_\_ ( \_\_, \_\_, \_\_, \_\_ )                      Date of Delivery (DOD): \_\_\_ / \_\_\_ / \_\_\_

6. Brief History of Present Illness/OB History

**PART II. PHYSICAL EXAMINATION**

**7. GENERAL SURVEY (PERTINENT FINDINGS PER SYSTEM)**

ANTENATAL CARE NO.	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	4 <sup>th</sup>
Date of visit: (mm/dd/yy)	___/___/___	___/___/___	___/___/___	___/___/___

VITAL SIGNS:

BP:				
Temperature:				
Weight:				

**8. SERVICES PROVIDED**

Tetanus Immunization:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MMS:	<input type="checkbox"/> Qty: _____	<input type="checkbox"/> Qty: _____	<input type="checkbox"/> Qty: _____	<input type="checkbox"/> Qty: _____
Iron:	<input type="checkbox"/> Qty: _____	<input type="checkbox"/> Qty: _____	<input type="checkbox"/> Qty: _____	<input type="checkbox"/> Qty: _____
Folic Acid:	<input type="checkbox"/> Qty: _____	<input type="checkbox"/> Qty: _____	<input type="checkbox"/> Qty: _____	<input type="checkbox"/> Qty: _____
Calcium:	<input type="checkbox"/> Qty: _____	<input type="checkbox"/> Qty: _____	<input type="checkbox"/> Qty: _____	<input type="checkbox"/> Qty: _____
Counseling:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family Planning:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nutrition Counseling:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lactation Management:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. REFERRED	<input type="checkbox"/> Reason	<input type="checkbox"/> Reason	<input type="checkbox"/> Reason	<input type="checkbox"/> Reason

10. Certification of Attending Physician/Midwife:  
*I certify that the above information given in this form are true and correct.*

SIGNATURE				
PRINTED NAME				

**11. PATIENT'S CONFORME**

SIGNATURE				
PRINTED NAME				

12. DATE SIGNED

- Reminders:
1. Write legibly in BLOCK LETTERS using black or blue ink only.
  2. Ensure all required fields are completely filled out; write "N/A" if not applicable.
  3. Provide accurate and updated patient and delivery information, including correct dates.
  4. Avoid erasures; if correction is needed, draw a single line over the error, write the correct entry, and affix your initials.
  5. Ensure the attending physician or midwife signs the form and review all entries before submission.
  6. This form shall be used upon patient discharge.