

MEDICAL RECORD	PRENATAL AND PREGNANCY	DATE
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PATIENT INFORMATION

LAST NAME				FIRST NAME				MIDDLE INITIAL	
STREET ADDRESS				CITY			STATE	ZIP CODE	
TELEPHONE (Home)		TELEPHONE (Work)			ID NUMBER		DAY OF BIRTH (Month, Day, Year)		AGE
AREA CODE	NUMBER	AREA CODE	NUMBER	EXT.					
RACE				EDUCATION (Last grade completed)			OCCUPATION		
WHITE	HISPANIC WHITE	AMERICAN INDIAN/ALASKA NATIVE					HOMEMAKER	OUTSIDE WORK	
BLACK	HISPANIC BLACK	ASIAN/PACIFIC ISLANDER					STUDENT		
MARITAL STATUS							TYPE OF WORK		
SINGLE		MARRIED		WIDOWED					
DIVORCED		SEPARATED							
HUSBAND/FATHER OF BABY				EMERGENCY CONTACT			TELEPHONE		
							AREA CODE	NUMBER	
NAME			TELEPHONE			NEWBORN'S PHYSICIAN			REFERRED BY
			AREA CODE	NUMBER					
FINAL ESTIMATED DELIVERY DATE		HOSPITAL OF DELIVERY			PRIMARY PROVIDER/GROUP			MEDICAID NUMBER/INSURANCE	

NUMBER OF PREGNANCIES

TOTAL	FULL TERM	PREMATURE	ABORTIONS INDUCED	ABORTIONS SPONTANEOUS	ECTOPICS	MULTIPLE BIRTHS	LIVING
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PAST PREGNANCIES (LAST SIX)

DATE (MO/YR)	GA WEEKS	LENGTH OF LABOR	BIRTH WEIGHT	SEX		TYPE DELIVERY	ANESTHESIA	PLACE OF DELIVERY	PRETERM LABOR DELIVERY		COMMENTS/COMPLICATIONS
				F	M				YES	NO	

MENSTRUAL HISTORY

LAST MENSTRUAL PERIOD			MENSES			FREQUENCY			MENARCHE	
DEFINITE	APPROXIMATE (MONTH KNOWN)		MONTHLY	PRIOR (Date)	Q (Days)	ON BCP AT CONCEPT		AGE ONSET	hCG + (Date)	
UNKNOWN	NORMAL AMOUNT/DURATION		YES							
FINAL:			NO			YES	NO			

SYMPTOMS SINCE LAST MENSTRUAL PERIOD

DESCRIBE ALL SYMPTOMS

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY		RECORDS MAINTAINED AT	
PATIENT'S IDENTIFICATION (For typed or written entries, give: Name -- last, first, middle; ID No. or SSN; Sex)			REGISTER NO.	WARD NO.

PRENATAL AND PREGNANCY
Medical Record

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
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PAST MEDICAL HISTORY

ITEM	O NEG + POS	DETAIL POSITIVE REMARKS (Include Date and Treatment)	ITEM	O NEG + POS	DETAIL POSITIVE REMARKS (Include Date and Treatment)
DIABETES			PULMONARY (TB, ASTHMA)		
HYPERTENSION			ALLERGIES (DRUGS)		
HEART DISEASE			BREAST		
AUTOIMMUNE DISORDER			HISTORY OF ABNORMAL PAP		
KIDNEY DISEASE/UTI			UTERINE ANOMALY/ DES		
PSYCHIATRIC			INFERTILITY		
NEUROLOGIC/ EPILEPSY			RELEVANT FAMILY HISTORY		
HEPATITIS/LIVER DISEASE			GYN SURGERY		
VARICOSITIES/ PHLEBITIS					
THYROID DYSFUNCTION			OPERATIONS/HOS- PITALIZATIONS (Year and Reason)		
TRAUMA/DOMESTIC VIOLENCE					
HISTORY OF BLOOD TRANSFUSION			ANESTHETIC COMPLICATIONS		
D (RH) SENSITIZED			OTHER (Specify)		

USE OF TOBACCO**USE OF ALCOHOL****USE OF STREET DRUGS**

NUMBER OF CIGARETTES PER DAY		NO. OF YEARS SMOKED	NUMBER OF DRINKS PER DAY		NO. OF YEARS DRINKING	AMOUNT PER DAY		NO. OF YEARS USE
PRIOR TO PREGNANCY	NOW		PRIOR TO PREGNANCY	NOW		PRIOR TO PREGNANCY	NOW	

COMMENTS/COUNSELING

GENETICS SCREENING/TERATOLOGY COUNSELING

(Includes Patient, Baby's Father, or anyone in Either Family)

ITEM	YES	NO	ITEM	YES	NO
PATIENT'S AGE IS GREATER THAN 35 YEARS			MENTAL RETARDATION/AUTISM		
THALASSEMIA (ITALIAN, GREEK, MEDITERRANEAN, OR ASIAN BACKGROUND (MCV IS LESS THAN 80))			IF YES, WAS PERSON TESTED FOR FRAGILE X		
NEURAL TUBE DEFECT (MENINGOMYELOCELE, SPINA BIFIDA, OR ANENCEPHALY)			OTHER INHERITED GENETIC OR CHROMOSOMAL DISORDER		
CONGENITAL HEART DEFECT			MATERIAL METABOLIC DISORDER *E.G., INSULIN-DEPENDENT DIABETES, PKU)		
DOWN SYNDROME			PATIENT OR BABY'S FATHER HAD A CHILD WITH BIRTH DEFECTS NOT LISTED ABOVE		
TAY-SACHS (E.G., JEWISH, CAJUN, FRENCH CANADIAN)			MEDICATIONS/STREET DRUGS/ALCOHOL SINCE LAST MENSTRUAL PERIOD		
SICKLE CELL DISEASE OR TRAIT (AFRICAN)			IF YES, LIST AGENT(S)		
HEMOPHILIA			ANY OTHER		
MUSCULAR DYSTROPHY					
CYSTIC FIBROSIS					
HUNTINGTON CHOREA					
RECURRENT PREGNANCY LOSS OR A STILLBIRTH					


COMMENTS/COUNSELING

INFECTION HISTORY

ITEM	YES		NO		ITEM	YES		NO	
HIGH RISK HEPATITIS B/IMMUNIZED					RASH OR VIRAL ILLNESS SINCE LAST MENSTRUAL PERIOD				
LIVE WITH SOMEONE WITH TB					HISTORY OF STD, GC, CHLAMYDIA, HPV, SYPHILIS				
EXPOSED TO TB					OTHER				
PATIENT OR PARTNER HAS HISTORY OF GENITAL HERPES									
COMMENTS									

DRUG ALLERGY	RELIGIOUS/CULTURAL CONSIDERATIONS	ANESTHESIA CONSULT PLANNED <input type="checkbox"/> YES <input type="checkbox"/> NO
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INTERVIEWER'S SIGNATURE **INITIAL PHYSICAL EXAMINATION**

EXAM DATE	PRE-PREGNANCY WEIGHT	PRESENT WEIGHT	HEIGHT	BP		
ITEM	CHECK ONE		ITEM	RESULT		
	NORMAL	ABNORMAL				
HEENT			VULVA	NORMAL	CONDYLOMA	LESIONS
FUNDI			VAGINA	NORMAL	INFLAMMATION	DISCHARGE
TEETH			CERVIX	NORMAL	INFLAMMATION	LESIONS
THYROID			UTERUS SIZE	NO. OF WEEKS:		FIBROIDS
BREASTS			ADNEXA	NORMAL	MASS	
LUNGS			DIAGONAL CONJUGATE	REACHED	NO	CM 
HEART			SPINES	AVERAGE	PROMINENT	BLUNT
ABDOMEN			SACRUM	CONCAVE	STRAIGHT	ANTERIOR
EXTREMITIES			SUBPUBIC ARCH	NORMAL	WIDE	NARROW
SKIN			GYNECOID PELVIC TYPE	YES	NO	
LYMPH NODES						
RECTUM						

COMMENTS (List type and explain abnormality)

PROBLEMS	PLANS	MEDICATION LIST		
		TYPE	START DATE	STOP DATE

ESTIMATED DELIVERY DATE (EDD)**CONFIRMATION**

ACTION	DATE	WEEKS	EDD	INITIAL EDD
LMP				
INITIAL EXAM				INITIALED BY
ULTRASOUND				

18-20 WEEK UPDATE

ACTION	ORIG. DATE	WEEKS	NEW DATE	FINAL EDD
QUICKENING				
FUNDAL HT. AT UMBIL.				INITIALED BY
FHT W/FETOSCOPE				
ULTRASOUND				

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REGISTER NO.

WARD NO.

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
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VISITS

DATE	WEEKS GEST. (BEST EST.)	FUNDAL HEIGHT (CM)	PRESENTATION	FHR	FETAL MOVEMENT	PRETERM LABOR SIGNS/SYMPOMS		CERVIX EXAM (DIL./EFF./ STA.)	BLOOD PRES- SURE	EDEMA	WEIGHT	URINE (GLUCOSE/ ALBUMIN)	NEXT APPOINT- MENT (Date)	PROVIDER (Initials)	COMMENTS
						PRESENT	ABSENT								

PROBLEMS

COMMENTS

LABORATORY AND EDUCATION

TYPE		DATE	RESULT				REVIEWED	COMMENTS/ADDITIONAL LAB
INITIAL LABS	BLOOD TYPE		A		B			
			AB		O			
	D (RH) TYPE							
	PAP TEST		NORMAL		OTHER			
			ABNORMAL					
	HIV COUNSELING/TESTING		POSITIVE		DECLINED			
			NEGATIVE					
	ANTIBODY SCREEN							
	RUBELLA							
	VDRL							
HCT/HGB		PERCENTAGE		G/DL				
URINE CULTURE/SCREEN								
HB s AG								
OPTIONAL LABS	HGB ELETROPHORESIS		AA	AS	SS	AC		
			SC	AF	TA2			
	PPD							
	CHLAMYDIA							
	GC							
	TAY-SACHS							
OTHER								
8-18 WEEK LABS <i>(When indicated/elected)</i>	ULTRASOUND							
	MSAFP/MULTIPLE MARKERS							
	AMNIO/CVS							
	KARYOTYPE		46, XX		OTHER			
			46, XY					
AMNIOTIC FLUID (AFP)		NORMAL		ABNORMAL				

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REGISTER NO.

WARD NO.

LAST NAME FIRST NAME MIDDLE INITIAL ID NUMBER

	TYPE	DATE	RESULT		REVIEWED	COMMENTS/ADDITIONAL LAB
24-28 WEEK LABS	HCT/HGB		PERCENTAGE	G/DL		
	DIABETES SCREEN		1 HOUR			
	GTT (<i>If screen abnormal</i>)		FBS	1 HOUR		
			2 HOUR	3 HOUR		
	D (RH) ANTIBODY SCREEN					
D IMMUNE GLOBULIN (RHG) GIVEN (<i>28 WEEKS</i>)		SIGNATURE				
32-36 WEEK LABS	HCT/HGB (<i>Recommended</i>)		PERCENTAGE	G/DL		
	ULTRASOUND					
	VDRL					
	GC					
	CHLAMYDIA					
	GROUP B STREP (<i>35-37 WEEKS</i>)					

PLANS/EDUCATION

TYPE	COMMENTS	TYPE	COMMENTS
COUNSELED		NEWBORN CAR SEAT	
ANESTHESIA PLANS		POSTPARTUM BIRTH CONTROL	
TOXOPLASMOSIS PRECAUTIONS (CATS/RAW MEAT)		ENVIRONMENTAL/WORK HAZARDS	
CHILDBIRTH CLASSES		TUBAL STERILIZATION	
PHYSICAL/SEXUAL ACTIVITY		VBAC COUNSELING	
LABOR SIGNS		CIRCUMCISION	
NUTRITION COUNSELING		TRAVEL	
BREAST OR BOTTLE FEEDING		LIFESTYLE, TOBACCO, ALCOHOL	

RESULTS	TUBAL STERILIZATION	
	DATE CONSENT SIGNED	INITIALS

COMMENTS/COUNSELING

SUPPLEMENTAL VISITS

DATE	WEEKS GEST. (BEST EST.)	FUNDAL HEIGHT (CM)	PRESENTATION	FHR	FETAL MOVEMENT	PRETERM LABOR SIGNS/SYMPTOMS		CERVIX EXAM (DIL./EFF./ STA.)	BLOOD PRES- SURE	EDEMA	WEIGHT	URINE (GLUCOSE/ ALBUMIN)	NEXT APPOINT- MENT (Date)	PROVIDER (Initials)	COMMENTS
						PRESENT	ABSENT								

PROGRESS NOTES

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REGISTER NO.

WARD NO.

LAST NAME

FIRST NAME

MIDDLE INITIAL

ID NUMBER

PROGRESS NOTES

DISCHARGE/POSTPARTUM

DELIVERY INFORMATION

DELIVERY DATE	TYPE OF DELIVERY					
	<input type="checkbox"/> VAGINAL			<input type="checkbox"/> CESAREAN		
DELIVERY AT (Weeks)	SVD	EPISIOTOMY	PRIMARY	FOR	REPEAT-FAILED VBAC	
	VACUUM	LACERATIONS			LOW TRANSVERSE	
	FORCEPS	VBAC	CLASSICAL	REPEAT - ELECTIVE	LOW VERTICAL	
LABOR			ANESTHESIA			
SPONTANEOUS	AUGMENTED		NONE	EPIDURAL	GENERAL	
INDUCED	NO LABOR		LOCAL/PUDENDAL	SPINAL	OTHER	

POSTPARTUM COMPLICATIONS

NONE	HEMORRHAGE	INFECTION	HYPERTENSION	OTHER:
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DISCHARGE INFORMATION

DISCHARGE DATE

NEONATAL

SEX		DISPOSITION			COMPLICATIONS/ANOMALIES
FEMALE	CIRCUMCISION		HOME WITH MOTHER	NEONATAL DEATH	
MALE	YES	NO	TRANSFER	OTHER	
BIRTH WEIGHT	NAME OF BABY		STILLBIRTH		
			IN HOSPITAL		

MATERNAL

HB/HCT LEVEL	CONTRACEPTIVE METHOD (If applicable)	MEDICATIONS
FEEDING METHOD	DIAGNOSTIC STUDIES PENDING	
BREAST	BOTTLE	
SECONDARY DIAGNOSIS/PREEXISTING CONDITIONS		FOLLOW-UP APPOINTMENT
ASTHMA	OTHER	DATE
DIABETES		LOCATION
HYPERTENSION		
IMMUNIZATIONS GIVEN		REMARKS
D (Rho)(D)) IMMUNE GLOBULIN		
DIABETES		
OTHER:		

INTERIM CONTACTS

DATE	COMMENT

SIGNATURE OF PROVIDER (AS REQUIRED)

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POSTPARTUM VISITS

DATE	ALLERGIES	MEDITATIONS/CONTRACEPTION
LAB STUDIES REQUESTED		MEDITATIONS/CONTRACEPTION DISPENSED <input type="checkbox"/> YES <input type="checkbox"/> NO
HGB/HCT	LAST PAP SMEAR (Date)	FEEDING METHOD
INTERIM HISTORY		CONTRACEPTIVE METHOD

INTERVAL CARE RECOMMENDATIONS

FOR GENERAL HEALTH PROMOTION

FOR REPRODUCTIVE HEALTH PROMOTION

REFERRALS

RETURN VISIT (Date)	EXAMINED BY
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PHYSICAL EXAM

BP	WEIGHT	PAP SMEAR <input type="checkbox"/> YES <input type="checkbox"/> NO
ITEM	NORMAL	ABNORMAL
BREASTS		
ABDOMEN		
EXTERNAL GENITALS		
VAGINA		
CERVIX		
UTERUS		
ADNEXA		
RECTAL-VAGINAL		
COMMENTS		

COMMENTS *(Continue on back if needed)*

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WARD NO.