PREVIOUS EDITION IS NOT USABLE

NSN 7540-00-634-4276

MEDICAL RECORD	PRENATAL AND PREGNANCY	DATE

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	
NAME	TELEPHONE			AREA CODE	NUMBER
	AREA CODE	NUMBER			
			NEWBORN'S PHYSICIAN	REFERRED BY	
FINAL ESTIMATED DELIVERY DATE	HOSPITAL OF DELIVERY		PRIMARY PROVIDER/GROUP	MEDICAID NUMBER/INSURANCE	

NUMBER OF PREGNANCIES

TOTAL	FULL TERM	PREMATURE	ABORTIONS INDUCTED	ABORTIONS SPONTANEOUS	ECTOPICS	MULTIPLE BIRTHS	LIVING

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			☐ YES	☐ NO		
☐	FINAL:			☐ 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

STANDARD FORM 533 (REV. 12-1999)
Prescribed by GSA/ICMR FMR (41 CFR) 101-11.203

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

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					
TAY-SACHS (E.G., JEWISH, CAJUN, FRENCH CANADIAN)			PATIENT OR BABY'S FATHER HAD A CHILD WITH BIRTH DEFECTS NOT LISTED ABOVE		
SICKLE CELL DISEASE OR TRAIT (AFRICAN)					
HEMOPHILIA			MEDICATIONS/STREET DRUGS/ALCOHOL SINCE LAST MENSTRUAL PERIOD		
MUSCULAR DYSTROPHY					
CYSTIC FIBROSIS			IF YES, LIST AGENT(S)		
HUNTINGTON CHOREA					
RECURRENT PREGNANCY LOSS OR A STILLBIRTH			ANY OTHER		

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 ☐ YES ☐ NO

INTERVIEWER'S SIGNATURE ▶

INITIAL PHYSICAL EXAMINATION

EXAM DATE	PRE-PREGNANCY WEIGHT	PRESENT WEIGHT	HEIGHT	BP

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

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				

PATIENT'S IDENTIFICATION *(For typed or written entries, give: Name -- last, first, middle; ID No. or SSN; Sex; Date of Birth; Rank/Grade)*	REGISTER NO.	WARD NO.

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

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								

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 ☐ ABNORMAL ☐ OTHER		
	HIV COUNSELING/TESTING		☐ POSITIVE ☐ NEGATIVE ☐ DECLINED		
	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 *(When indicated/elected)*	ULTRASOUND				
	MSAFP/MULTIPLE MARKERS				
	AMNIO/CVS				
	KARYOTYPE		☐ 46, XX ☐ 46, XY ☐ OTHER		
	AMNIOTIC FLUID (AFP)		☐ NORMAL ☐ ABNORMAL		

PATIENT'S IDENTIFICATION *(For typed or written entries, give: Name -- last, first, middle; ID No. or SSN; Sex; Rank/Grade)*

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 *(If screen abnormal)*		FBS	1 HOUR		
			2 HOUR	3 HOUR		
	D (RH) ANTIBODY SCREEN					
	D IMMUNE GLOBULIN (RHG) GIVEN *(28 WEEKS)*		SIGNATURE			
32-36 WEEK LABS	HCT/HGB *(Recommended)*		PERCENTAGE	G/DL		
	ULTRASOUND					
	VDRL					
	GC					
	CHLAMYDIA					
	GROUP B STREP *(35-37 WEEKS)*					

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

PATIENT'S IDENTIFICATION *(For typed or written entries, give: Name -- last, first, middle; ID No. or SSN; Sex; Rank/Grade)*	REGISTER NO.	WARD NO.

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

PROGRESS NOTES

DISCHARGE/POSTPARTUM

DELIVERY INFORMATION

DELIVERY DATE	TYPE OF DELIVERY							
	☐ VAGINAL					☐ 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:

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 ☐ BREAST ☐ BOTTLE	DIAGNOSTIC STUDIES PENDING	

SECONDARY DIAGNOSIS/PREEXISTING CONDITIONS		FOLLOW-UP APPOINTMENT	
☐ ASTHMA	OTHER	DATE	LOCATION
☐ DIABETES			
☐ HYPERTENSION			

IMMUNIZATIONS GIVEN	REMARKS
☐ D (Rho)(D)) IMMUNE GLOBULIN	
☐ DIABETES	
☐ OTHER:	

INTERIM CONTACTS

DATE	COMMENT

SIGNATURE OF PROVIDER *(AS REQUIRED)*

PATIENT'S IDENTIFICATION *(For typed or written entries, give: Name -- last, first, middle; ID No. or SSN; Sex; Rank/Grade)*	REGISTER NO.	WARD NO.

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

POSTPARTUM VISITS

DATE ALLERGIES

LAB STUDIES REQUESTED

MEDICATIONS/CONTRACEPTION

HGB/HCT

LAST PAP SMEAR *(Date)*

MEDICATIONS/CONTRACEPTION DISPENSED

☐ YES ☐ NO

INTERIM HISTORY

FEEDING METHOD

CONTRACEPTIVE METHOD

INTERVAL CARE RECOMMENDATIONS

FOR GENERAL HEALTH PROMOTION

FOR REPRODUCTIVE HEALTH PROMOTION

REFERRALS

RETURN VISIT *(Date)*	EXAMINED BY

PHYSICAL EXAM

BP	WEIGHT	PAP SMEAR ☐ YES ☐ NO

ITEM	NORMAL	ABNORMAL	COMMENTS
BREASTS			
ABDOMEN			
EXTERNAL GENITALS			
VAGINA			
CERVIX			
UTERUS			
ADNEXA			
RECTAL-VAGINAL			

COMMENTS

COMMENTS *(Continue on back if needed)*

PATIENT'S IDENTIFICATION *(For typed or written entries, give: Name -- last, first, middle; ID No. (SSN or other); hospital or medical facility)*	REGISTER NO.	WARD NO.