ANTEPARTUM RECORD

DATE _____

NAME _____
LAST FIRST MIDDLE

ID# _____ HOSPITAL OF DELIVERY _____

NEWBORN'S PHYSICIAN _____ REFERRED BY _____

FINAL EDD _____ PRIMARY PROVIDER/GROUP _____

BIRTHDATE	AGE	RACE	MARITALSTATUS S M W D SEP	ADDRESS
OCCUPATION ☐ HOMEMAKER ☐ OUTSIDE WORK ☐ STUDENT Type of Work			EDUCATION (LAST GRADE COMPLETED)	ZIP PHONE (H) (O) INSURANCE CARRIER/MEDICAID#
HUSBAND/FATHER OF BABY			PHONE	EMERGENCY CONTACT PHONE

TOTAL PREG	FULLTERM	PREMATURE	AB.INDUCED	AB.SPONTANEOUS	MULTIPLE BIRTHS	ECTOPICS	LIVING

MENSTRUAL HISTORY

LM ☐ DEFINITE ☐ APPROXIMATE (MONTH KNOWN) MENES MONTHLY ☐ YES ☐ NO FREQUENCY: Q_____ DAYS MENARCH _____(AGE ONSET)
☐ UNKNOWN ☐ NORMAL AMOUNT / DURATION PRIOR MENES_____ DATE ONBCPATCONCEPT. ☐ YES ☐ NO hCG+ _____ /_____ /_____
☐ FINAL _____

PAST PREGNANCIES (LAST SIX)

DATE MONTH/ YEAR	GA WEEKS	LENTGH OF LABOR	BIRTH WEIGHT	SEX M/F	TYPE DELIVERY	ANES	PLACEOF DELIVERY	PRETERM LABOR YES/NO	COMMENTS/COMPLICATIONS

PAST MEDICAL HISTORY

	ONeg +Pos	DETAIL POSITIVE REMARKS INCLUDE DATE & TREATMENT				ONeg +Pos	DETAIL, POSITIVE REMARKS INCLUDE DATE & TREATMENT
1.DIABETES					16.D(Rh) SENSITIZED		
2.HYPERTENSION					17.PULMONARY (TB,ASTHMA)		
3.HEART DISEASE					18.ALLERGIES (DRUGS)		
4.AUTO IMMUNE DISORDER					19.BREAST		
5.KIDNEY DISEASE/UTI					20.GYN SURGERY		
6.NEUROLOGIC/EPILEPSY							
7.PSYCHIATRIC							
8.HEPATITIS/LIVER DISEASE					21.OPERATION/HOSPITALIZATIONS (YEAR & REASON)		
9.VARICOSITIES/PHLEBITIS							
10.THYROID DYSFUNCTION							
11.TRAUMA/DOMESTIC VIOLENCE					22.ANESTHETIC COMPLICATIONS		
12.HISTORY OF BLOOD TRANSFS					23.HISTORY OF ABNORMAL PAP		
	AMT/DAY PRE-PREG	AMT/DAY PRE-PREG	#YEARS USE		24.UTERINE ANOMALY / DES		
13.TOBACCO					25.INFERTILITY		
14.ALCOHOL					26.RELEVANT FAMILY HISTORY		
15.STREET DRUGS					27.OTHER		

COMMENTS: _____

SYMPTOMS SINCE LMP

	YES	NO		YES	NO
1.PATIENT'S AGE(35 OR OLDER)			12.MENTAL RETARDATION / AUTISM		
2.THALASSEMIA (ITALIAN, GREEK, MEDITERRANEAN,OR ASIAN BACKGROUND) MCV<80			IF YES,WAS PERSON TREATED FOR FRAGILEX?		
3.NEURAL TUBE DEFECT (MENINGOMYELOCELE,SPINABIFIDA,ORANENCEPHALY)			13.OTHER INHERITED GENETIC OR CHROMOSOMAL DISORDER		
4.CONGENITAL HEART DEFECT			14.MATERNAL METABOLIC DISORDER (EG.INSULINDEPENDENT DIABETES,PKU)		
5.DOWN SYNDROME			15.PATIENT OR BABY'S FATHER HAD A CHILD WITH BIRTH DEFECTS NOT LISTED ABOVE		
6.TAY-SACHS(EG.JEWISH,CAJUN,FRENCH-CANADIAN			16.RECURRENT PREGNANCY LOSS,OR A STILL BIRTH		
7.SICKLE CELL DISEASE OR TRAIT(AFRICAN)			17.MEDICATIONS/STREET DRUGS/ALCOHOL SINCE LAST MENSTRUAL PERIOD		
8.HEMOPHILIA			IFYES,AGENT(S)		
9.MUSCULAR DYSTROPHY					
10.CYSTIC FIBROSIS			18.ANY OTHER		
11.HUNTINGTON CHOREA					

COMMENTS/COUNSELING _____

INFECTION HISTORY	YES	NO		YES	NO
1.HIGH RISK HEPATITIS B / IMMUNIZED?			4.RASH OR VIRAL ILLNESS SINCE LAST MENSTRUAL PERIOD		
2.LIVE WITH SOMEONE WITH TB OR EXPOSED TO TB			5.HISTORY OF STD.GC.CHLAMYDIA.HPV.SYPHILIS		
3.PATIENT OR PARTNER HAS HISTORY OFGENITAL HERPES			6.OTHER(SEE COMMENTS)		

COMMENTS _____

INTERVIEWER'S SIGNATURE _____

INITIAL PHYSICAL EXAMINATION

DATE ____ / ____ / ____ PRE-PREGNANCY WEIGHT _____ HEIGH _____ BP _____

1.HEENT	NORMAL	ABNORMAL	12.VULVA	NORMAL	ABNORMAL		
2.FUNDI	NORMAL	ABNORMAL	13.VAGINA	NORMAL	ABNORMAL		
3.TEETH	NORMAL	ABNORMAL	14.CERVIX	NORMAL	ABNORMAL		
4.THYROID	NORMAL	ABNORMAL	15.UTERUS SIZE	NORMAL	ABNORMAL		
5.BREASTS	NORMAL	ABNORMAL	16.ADNEXA	NORMAL	ABNORMAL		
6.LUNGS	NORMAL	ABNORMAL	17.RECTUM	NORMAL	ABNORMAL		
7.HEART	NORMAL	ABNORMAL	18.DIAGONAL CONJUGATE	NORMAL	ABNORMAL		
8.ABDOMEN	NORMAL	ABNORMAL	19.SPINES	NORMAL	ABNORMAL		
9.EXTREMITIES	NORMAL	ABNORMAL	20.SACRUM	NORMAL	ABNORMAL		
10.SKIN	NORMAL	ABNORMAL	21.SUBPUBICARCH	NORMAL	ABNORMAL		
11.LYMPHNODE	NORMAL	ABNORMAL	22.GYNECOD PELVIC TYPE	NORMAL	ABNORMAL		

COMMENTS (Number and explain abnormals) _____

EXAMED BY _____

NAME _____

LAST FIRST MIDDLE

DRUG ALLERGY

RELIGIOUS / CULTURAL CONSIDERATIONS _____ ANESTHESIA CONSULT PLANNED ☐ YES ☐ NO

PROBLEMS/PLANS	**MEDICATION LIST:**	Start Date	Stop Date
1.	1.		
2.	2.		
3.	3.		
4.	4.		
5.	5.		
6.	6.		

EDD CONFIRMATION

INITIAL EDD:

LMP ____ / ____ / ____ = EDD ____ / ____ / ____

INITIAL EXAM ____ / ____ / ____ = ____ WKS = EDD ____ / ____ / ____

ULTRASOUND ____ / ____ / ____ = ____ WKS = EDD ____ / ____ / ____

INITIAL EDD ____ / ____ / ____ INITIAL ED BY _____

18-20-WEEK EDD UPDATE:

QUICKENING ____ / ____ / ____ +22WKS = ____ / ____ / ____

FUNDALHT.ATUMBIL ____ / ____ / ____ +20WKS = ____ / ____ / ____

FHTW/FETO SCOPE ____ / ____ / ____ +20WKS = ____ / ____ / ____

ULTRASOUND ____ / ____ / ____ = ____ WKS = ____ / ____ / ____

FINAL EDD ____ / ____ / ____ INITIAL ED BY _____

VISIT DATE

____
(YEAR)

Weeks Gest. (EST.)	Fundal Height (CM)	Present-ation	FHR	Fetal Movmnt	Preterm Labor Signs/Symptoms + - Present 0 - Absent	Cervix Exam (DIL/EFF/STA)	Blood Pressure	Edema	Weight	Urine (Glucose/Albumin)	Next Appt	Provider Signature	**COMMENTS:**

PROBLEMS: _____

COMMENTS: _____

LABORATORY AND EDUCATION

INITIAL LABS	DATE	RESULT	REVIEWED
BLOOD TYPE	___/___/___	A B AB O	
D(Rh) TYPE	___/___/___		
ANTIBODY SCREEN	___/___/___		
HCT/HGB	___/___/___	___% ___g/dl	
PAP TEST	___/___/___	NORMAL/ABNORMAL/ ___	
RUBELLA	___/___/___		
VDRL	___/___/___		
URINE CULTURE / SCREEN	___/___/___		
HBsAg	___/___/___		
HIV COUNSELING / TESTING	___/___/___	☐ POS ☐ NEG ☐ DECLINED	
OPTIONAL LABS	**DATE**	**RESULT**	**REVIEWED**
HGB ELECTROPHORESIS	___/___/___	AA AS SS AC SC AF Ta2	
PPD	___/___/___		
CHLAMYDIA	___/___/___		
GC	___/___/___		
TAY-SACHS	___/___/___		
OTHER	___/___/___		
8-18-WEEK LABS (WHEN INDICATED)	**DATE**	**RESULT**	**REVIEWED**
ULTRASOUND	___/___/___		
MSAFP/MULTIPLE MARKERS	___/___/___		
AMNIO/CVS	___/___/___		
KARYOTYPE	___/___/___	46.XX OR 46.XY / OTHER	
AMINOTIC FLUID(AFP)	___/___/___	NORMAL ☐ ABNORMAL ☐	
24-28-WEEK LABS (WHEN INDICATED)	**DATE**	**RESULT**	**REVIEWED**
HCT/HGB	___/___/___	___% ___g/dl	
DIABETES SCREEN	___/___/___	___ 1HOUR	
GTT (IF SCREEN ABNORMAL)	___/___/___	___ FBS ___ 1HOUR ___ 2HOUR ___ 3HOUR	
D(Rh) ANTIBODY SCREEN	___/___/___		
D IMMUNE GLOBULIN(RhIG)GIVEN(28WKS)	___/___/___	SIGNATURE ___	
32-36-WEEK LABS (WHEN INDICATED)	**DATE**	**RESULT**	**REVIEWED**
HCT/HGB(RECOMMENDED)	___/___/___	___% ___g/dl	
ULTRASOUND	___/___/___		
VDRL	___/___/___		
GC	___/___/___		
CHLAMYDIA	___/___/___		
GROUP B STREP(35-37WKS)	___/___/___		

COMMENTS/ADDITIONAL LABS

PLANS/EDUCATION (COUNSELED ☐)

- ☐ ANESTHESIA PLANS ___
- ☐ TOXOPLASMOSIS PRECAUTIONS (CATS/RAWMEAT) ___
- ☐ CHILD BIRTH CLASSESS ___
- ☐ PHYSICAL/SEXUAL ACTIVITY ___
- ☐ LABOR SIGNS ___
- ☐ NUTRITION COUNSELING ___
- ☐ BREAST OR BOTTLE FEEDING ___
- ☐ NEWBORN CARSEAT ___
- ☐ POSTPARTUM BIRTHCONTROL ___
- ☐ ENVIRONMENTAL/WORKHAZARDS ___
- ☐ TUBAL STERILIZATION ___
- ☐ VSAC COUNSELING ___
- ☐ CIRCUMCISION ___
- ☐ TRAVEL ___
- ☐ LIFESTYLE,TOBACCO,ALCOHOL ___

REQUESTS ___

TUBAL STERILIZATION DATE INITIALS

CONSENT SIGNED ___/___/___ ___

PROVIDER SIGNATURE(REQUIRED) ___

NAME _____
LAST FIRST MIDDLE

ID# _____

Supplemental Visits

VISITDATE (YEAR)	Weeks Gest. (EST.)	Fundal Height (CM)	Present-ation	FHR	Fetal Movmnt	Preterm Labor Signs/Symptoms + - Present o - Absent	Cervix Exam (DIL/EFF /STA)	Blood Pressure	Edema	Weight	Urine (Glucose/ Albumin)	Next Appt.	Provider (Initials)	COMMENTS:

Progress Notes

PROVIDER SIGNATURE (REQUIRED) _____

NAME _____

LAST FIRST MIDDLE

ID# _____

ProgressNotes

PROVIDER SIGNATURE (REQUIRED) _____