

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
BLACK	HISPANIC BLACK	ASIAN/PACIFIC ISLANDER		STUDENT						
MARITAL STATUS				EMERGENCY CONTACT		TELEPHONE				
										SINGLE
DIVORCED	SEPARATED				AREA CODE		NUMBER			
HUSBAND/FATHER OF BABY				NEWBORN'S PHYSICIAN		REFERRED BY				
NAME		TELEPHONE		PRIMARY PROVIDER/GROUP		MEDICAID NUMBER/INSURANCE				
		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.
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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	
	YES	NO		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	<input type="checkbox"/> NORMAL	<input type="checkbox"/> CONDYLOMA <input type="checkbox"/> LESIONS
FUNDI			VAGINA	<input type="checkbox"/> NORMAL	<input type="checkbox"/> INFLAMMATION <input type="checkbox"/> DISCHARGE
TEETH			CERVIX	<input type="checkbox"/> NORMAL	<input type="checkbox"/> INFLAMMATION <input type="checkbox"/> LESIONS
THYROID			UTERUS SIZE	NO. OF WEEKS: <input type="checkbox"/> FIBROIDS	
BREASTS			ADNEXA	<input type="checkbox"/> NORMAL	<input type="checkbox"/> MASS
LUNGS			DIAGONAL CONJUGATE	<input type="checkbox"/> REACHED	<input type="checkbox"/> NO <input type="checkbox"/> CM
HEART			SPINES	<input type="checkbox"/> AVERAGE	<input type="checkbox"/> PROMINENT <input type="checkbox"/> BLUNT
ABDOMEN			SACRUM	<input type="checkbox"/> CONCAVE	<input type="checkbox"/> STRAIGHT <input type="checkbox"/> ANTERIOR
EXTREMITIES			SUBPUBIC ARCH	<input type="checkbox"/> NORMAL	<input type="checkbox"/> WIDE <input type="checkbox"/> NARROW
SKIN			GYNECOID PELVIC TYPE	<input type="checkbox"/> YES	<input type="checkbox"/> 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				

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/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 (When indicated/elected)	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
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	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

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