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			

FINAL ESTIMATED DELIVERY DATE	HOSPITAL OF DELIVERY	NEWBORN'S PHYSICIAN	REFERRED BY

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.

NSN 7540-00-634-4276

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 PRESENT	PRETERM LABOR SIGNS/SYMPTOMS ABSENT	CERVIX EXAM (DIL./EFF./ STA.)	BLOOD PRES-SURE	EDEMA	WEIGHT	URINE (GLUCOSE/ ALBUMIN)	NEXT APPOINT-MENT *(Date)*	PROVIDER *(Initials)*	COMMENTS
						☐	☐			☐					
						☐	☐			☐					
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						☐	☐			☐					
						☐	☐			☐					

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 PRESENT	ABSENT	CERVIX EXAM (DIL./EFF./ STA.)	BLOOD PRES-SURE	EDEMA	WEIGHT	URINE (GLUCOSE/ ALBUMIN)	NEXT APPOINT-MENT *(Date)*	PROVIDER *(Initials)*	COMMENTS
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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	DIAGNOSTIC STUDIES PENDING	
☐ BREAST ☐ BOTTLE		

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.