

DATE: \_\_\_\_\_  
 NAME: \_\_\_\_\_  
 LAST FIRST MIDDLE  
 ID #: \_\_\_\_\_ HOSPITAL OF DELIVERY: \_\_\_\_\_  
 NEWBORN CARE PROVIDER: \_\_\_\_\_ REFERRED BY: \_\_\_\_\_

PRIMARY PROVIDER/GROUP: \_\_\_\_\_

FINAL EDD: _____		ADDRESS: _____	
BIRTH DATE: _____ MONTH DAY YEAR	AGE: _____	RACE: _____	MARITAL STATUS: _____ S M W D SEP
OCCUPATION: _____		EDUCATION: _____ (LAST GRADE COMPLETED)	
LANGUAGE: _____		ETHNICITY: _____	
HUSBAND/DOMESTIC PARTNER: _____		PHONE: _____	
FATHER OF BABY: _____		PHONE: _____	
TOTAL PREG: _____	FULL TERM: _____	PREMATURE: _____	AB. INDUCED: _____
AB. SPONTANEOUS: _____		ECTOPICS: _____	MULTIPLE BIRTHS: _____
LIVING: _____			

**MENSTRUAL HISTORY**

LMP  DEFINITE  APPROXIMATE (MONTH KNOWN) MENSES MONTHLY  YES  NO FREQUENCY: Q \_\_\_\_\_ DAYS MENARCHE: \_\_\_\_\_ (AGE ONSET)  
 UNKNOWN  NORMAL AMOUNT/DURATION PRIOR MENSES: \_\_\_\_\_ DATE ON BCP AT CONCEPT  YES  NO hCG + \_\_\_\_/\_\_\_\_/\_\_\_\_  
 FINAL: \_\_\_\_\_

**PAST PREGNANCIES (LAST SIX)**

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

**MEDICAL HISTORY**

	○ Neg. + Pos.	DETAIL POSITIVE REMARKS INCLUDE DATE & TREATMENT	○ Neg. + Pos.	DETAIL POSITIVE REMARKS INCLUDE DATE & TREATMENT		
A. DRUG/LATEX ALLERGIES/ REACTIONS				18. OPERATIONS/HOSPITALIZATIONS (YEAR & REASON)		
B. ALLERGIES (FOOD, SEASONAL, ENVIRONMENTAL)			19. GYN SURGERY			
1. NEUROLOGIC/EPILEPSY			20. ANESTHETIC COMPLICATIONS			
2. THYROID DYSFUNCTION			21. HISTORY OF BLOOD TRANSFUSIONS			
3. BREAST DISEASE			22. INFERTILITY			
4. PULMONARY (TB, ASTHMA)			23. ASSISTED REPRODUCTIVE TECHNOLOGY			
5. HEART DISEASE			24. UTERINE ANOMALY/DES			
6. HYPERTENSION			25. HISTORY OF ABNORMAL PAP			
7. CANCER			26. HISTORY OF STI			
8. HEMATOLOGIC DISORDERS			27. PSYCHIATRIC ILLNESS			
9. ANEMIA			28. DEPRESSION/POSTPARTUM DEPRESSION			
10. GASTROINTESTINAL DISORDERS			29. TRAUMA/VIOLENCE			
11. HEPATITIS/LIVER DISEASE						
12. KIDNEY DISEASE/UTI						
13. VARICOSITIES/PHLEBITIS						
14. DIABETES (TYPE 1 OR TYPE 2)						
15. GESTATIONAL DIABETES						
16. AUTOIMMUNE DISORDERS						
17. DERMATOLOGIC DISORDERS						
				PREPREG	PREG	# YEARS USE
				30. TOBACCO (AMT/DAY)		
				31. ALCOHOL (AMT/WK)		
				32. ILLICIT/RECREATIONAL DRUGS (USES/WK)		
				33. RELEVANT FAMILY HISTORY		
				34. OTHER		

COMMENTS: \_\_\_\_\_

PATIENT NAME:	BIRTH DATE: / /	ID NO.:	DATE: / /
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**GENETIC SCREENING\*TERATOLOGY COUNSELING**  
**INCLUDES PATIENT, BABY'S FATHER, OR ANYONE IN EITHER FAMILY WITH:**

	YES	NO		YES	NO
1. THALASSEMIA (ITALIAN, GREEK, MEDITERRANEAN, OR ASIAN BACKGROUND): MCV LESS THAN 80			12. HUNTINGTON CHOREA		
2. NEURAL TUBE DEFECT (MENINGOMYELOCELE, SPINA BIFIDA, OR ANENCEPHALY)			13. MENTAL RETARDATION/AUTISM IF YES, WAS PERSON TESTED FOR FRAGILE X?		
3. CONGENITAL HEART DEFECT			14. OTHER INHERITED GENETIC OR CHROMOSOMAL DISORDER		
4. DOWN SYNDROME			15. MATERNAL METABOLIC DISORDER (EG, TYPE 1 DIABETES, PKU)		
5. TAY-SACHS (ASHKENAZI JEWISH, CAJUN, FRENCH CANADIAN)			16. BIRTH DEFECTS NOT LISTED ABOVE		
6. CANAVAN DISEASE (ASHKENAZI JEWISH)			17. RECURRENT PREGNANCY LOSS OR A STILLBIRTH		
7. FAMILIAL DYSAUTONOMIA (ASHKENAZI JEWISH)			18. MEDICATIONS (INCLUDING SUPPLEMENTS, VITAMINS, HERBS, OR OTC DRUGS)/ILLICIT/RECREATIONAL DRUGS/ALCOHOL SINCE LAST MENSTRUAL PERIOD		
8. SICKLE CELL DISEASE OR TRAIT (AFRICAN AMERICAN)			IF YES, AGENT(S) AND STRENGTH/DOSAGE		
9. HEMOPHILIA OR OTHER BLOOD DISORDERS			19. ANY OTHER		
10. MUSCULAR DYSTROPHY					
11. CYSTIC FIBROSIS					

\*If a patient has been screened for a genetic disorder previously, the results should be documented but the test should not be repeated.

**COMMENTS/COUNSELING:** \_\_\_\_\_

INFECTION HISTORY	YES	NO	
1. LIVE WITH SOMEONE WITH TB OR EXPOSED TO TB			5. HISTORY OF STIs: GONORRHEA, CHLAMYDIA, HPV, SYPHILIS, PID (CIRCLE ALL THAT APPLY)
2. PATIENT OR PARTNER HAS HISTORY OF GENITAL HERPES			6. HIV INFECTION YES <input type="checkbox"/> NO <input type="checkbox"/>
3. RASH OR VIRAL ILLNESS SINCE LAST MENSTRUAL PERIOD			7. HISTORY OF HEPATITIS
4. PRIOR GBS-INFECTED CHILD			8. OTHER (SEE COMMENTS)

**COMMENTS:** \_\_\_\_\_

**INTERVIEWER'S SIGNATURE:** \_\_\_\_\_

IMMUNIZATIONS	YES (MONTH/YEAR) _____ / _____	NO	IF NO, POSTPARTUM VACCINE INDICATED?	IMMUNIZATIONS	YES (MONTH/YEAR) _____ / _____	NO	IF NO, POSTPARTUM VACCINE INDICATED?
TDAP or TD				HEPATITIS A (WHEN INDICATED)			
INFLUENZA†				HEPATITIS B (WHEN INDICATED)			
VARICELLA†				MENINGOCOCCAL (WHEN INDICATED)			
MMR†				PNEUMOCOCCAL (WHEN INDICATED)			

†All live vaccines are contraindicated in pregnancy, including the live intranasal influenza, MMR, and varicella vaccines. All women who will be pregnant during influenza season (October through May) should receive inactivated influenza vaccine at any point in gestation. Administer the MMR and varicella vaccines postpartum if needed.

**INITIAL PHYSICAL EXAMINATION**

DATE: _____ / _____ / _____		WEIGHT: _____		HEIGHT: _____		BMI: _____		BP: _____	
1. HEENT	<input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL	12. VULVA	<input type="checkbox"/> NORMAL <input type="checkbox"/> CONDYLOMA <input type="checkbox"/> LESIONS						
2. TEETH	<input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL	13. VAGINA	<input type="checkbox"/> NORMAL <input type="checkbox"/> INFLAMMATION <input type="checkbox"/> DISCHARGE						
3. SYMPTOMS SINCE LMP	<input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL	14. CERVIX	<input type="checkbox"/> NORMAL <input type="checkbox"/> INFLAMMATION <input type="checkbox"/> LESIONS						
4. THYROID	<input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL	15. UTERUS SIZE	_____ WEEKS <input type="checkbox"/> FIBROIDS						
5. BREASTS	<input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL	16. ADNEXA	<input type="checkbox"/> NORMAL <input type="checkbox"/> MASS						
6. LUNGS	<input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL	17. RECTUM	<input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL						
7. HEART	<input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL	18. DIAGONAL CONJUGATE	<input type="checkbox"/> REACHED <input type="checkbox"/> NO _____ CM						
8. ABDOMEN	<input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL	19. SPINES	<input type="checkbox"/> AVERAGE <input type="checkbox"/> PROMINENT <input type="checkbox"/> BLUNT						
9. EXTREMITIES	<input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL	20. SACRUM	<input type="checkbox"/> CONCAVE <input type="checkbox"/> STRAIGHT <input type="checkbox"/> ANTERIOR						
10. SKIN	<input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL	21. SUBPUBIC ARCH	<input type="checkbox"/> NORMAL <input type="checkbox"/> WIDE <input type="checkbox"/> NARROW						
11. LYMPH NODES	<input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL	22. GYNECOID PELVIC TYPE	<input type="checkbox"/> YES <input type="checkbox"/> NO						

**COMMENTS** (Number and explain abnormalities): \_\_\_\_\_

**EXAM BY:** \_\_\_\_\_

PHOTO COPYED FROM THE ORIGINAL DOCUMENT