DATE _____

NAME _____
LAST FIRST MIDDLE

ID # _____ HOSPITAL OF DELIVERY _____

NEWBORN'S PHYSICIAN _____ REFERRED BY _____

PRIMARY PROVIDER/GROUP _____

FINAL EDD _____

ADDRESS _____

BIRTH DATE MONTH DAY YEAR AGE RACE MARITAL STATUS S M W D SEP	ADDRESS
OCCUPATION EDUCATION (LAST GRADE COMPLETED)	ZIP PHONE (H) (O)
LANGUAGE ETHNICITY	INSURANCE CARRIER/MEDICAID #
HUSBAND/DOMESTIC PARTNER PHONE	POLICY #
FATHER OF BABY PHONE	EMERGENCY CONTACT 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 DELIVERY	ANES.	PLACE OF DELIVERY	PRETERM LABOR YES/NO	COMMENTS/ COMPLICATIONS

MEDICAL HISTORY

	○ Neg. + Pos.	DETAIL POSITIVE REMARKS INCLUDE DATE & TREATMENT
1. DIABETES		
2. HYPERTENSION		
3. HEART DISEASE		
4. AUTOIMMUNE DISORDER		
5. KIDNEY DISEASE/UTI		
6 NEUROLOGIC/EPILEPSY		
7 PSYCHIATRIC		
8. DEPRESSION/POSTPARTUM DEPRESSION		
9. HEPATITIS/LIVER DISEASE		
10. VARICOSITIES/PHLEBITIS		
11. THYROID DYSFUNCTION		
12. TRAUMA/VIOLENCE		
13. HISTORY OF BLOOD TRANSFUS.		

	AMT/DAY PREPREG	AMT/DAY PREG	# YEARS USE
14. TOBACCO			
15. ALCOHOL			
16. ILLICIT/RECREATIONAL DRUGS			

	○ Neg. + Pos.	DETAIL POSITIVE REMARKS INCLUDE DATE & TREATMENT
17. D (Rh) SENSITIZED		
18. PULMONARY (TB, ASTHMA)		
19. SEASONAL ALLERGIES		
20. DRUG/LATEX ALLERGIES/ REACTIONS		
21. BREAST		
22. GYN SURGERY		
23. OPERATIONS/ HOSPITALIZATIONS (YEAR & REASON)		
24. ANESTHETIC COMPLICATIONS		
25. HISTORY OF ABNORMAL PAP		
26. UTERINE ANOMALY/DES		
27. INFERTILITY		
28. ART TREATMENT		
29. RELEVANT FAMILY HISTORY		
30. OTHER		

COMMENTS _____

ANTEPARTUM RECORD

SYMPTOMS SINCE LMP

GENETIC SCREENING/TERATOLOGY COUNSELING

INCLUDES PATIENT, BABY'S FATHER, OR ANYONE IN EITHER FAMILY WITH:

	YES	NO
1 PATIENT'S AGE 35 YEARS OR OLDER AS OF ESTIMATED DATE OF DELIVERY		
2. THALASSEMIA (ITALIAN, GREEK, MEDITERRANEAN, OR ASIAN BACKGROUND); MCV LESS THAN 80		
3 NEURAL TUBE DEFECT (MENINGOMYELOCELE, SPINA BIFIDA, OR ANENCEPHALY)		
4. CONGENITAL HEART DEFECT		
5. DOWN SYNDROME		
6 TAY-SACHS (ASHKENAZI JEWISH, CAJUN, FRENCH CANADIAN)		
7. CANAVAN DISEASE (ASHKENAZI JEWISH)		
8. FAMILIAL DYSAUTONOMIA (ASHKENAZI JEWISH)		
9. SICKLE CELL DISEASE OR TRAIT (AFRICAN)		
10. HEMOPHILIA OR OTHER BLOOD DISORDERS		
11. MUSCULAR DYSTROPHY		
12. CYSTIC FIBROSIS		

	YES	NO
13. HUNTINGTON'S CHOREA		
14. MENTAL RETARDATION/AUTISM		
IF YES, WAS PERSON TESTED FOR FRAGILE X?		
15. OTHER INHERITED GENETIC OR CHROMOSOMAL DISORDER		
16. MATERNAL METABOLIC DISORDER (EG. TYPE 1 DIABETES, PKU)		
17. PATIENT OR BABY'S FATHER HAD A CHILD WITH BIRTH DEFECTS NOT LISTED ABOVE		
18. RECURRENT PREGNANCY LOSS, OR A STILLBIRTH		
19. MEDICATIONS (INCLUDING SUPPLEMENTS, VITAMINS, HERBS OR OTC DRUGS)/ILLICIT/RECREATIONAL DRUGS/ALCOHOL SINCE LAST MENSTRUAL PERIOD		
IF YES, AGENT(S) AND STRENGTH/DOSAGE		
20. ANY OTHER		

COMMENTS/COUNSELING _____

_____

INFECTION HISTORY	YES	NO
1. LIVE WITH SOMEONE WITH TB OR EXPOSED TO TB		
2. PATIENT OR PARTNER HAS HISTORY OF GENITAL HERPES		
3. RASH OR VIRAL ILLNESS SINCE LAST MENSTRUAL PERIOD		

4. HEPATITIS B, C YES ☐ NO ☐

5. HISTORY OF STD, GONORRHEA, CHLAMYDIA, HPV, HIV, SYPHILIS (CIRCLE ALL THAT APPLY)

6. OTHER (SEE COMMENTS)

COMMENTS _____

_____ INTERVIEWER'S SIGNATURE _____

INITIAL PHYSICAL EXAMINATION

DATE ____/____/____ WEIGHT _____ HEIGHT _____ BMI _____ BP_____

1. HEENT	☐ NORMAL	☐ ABNORMAL	12. VULVA	☐ NORMAL	☐ CONDYLOMA ☐ LESIONS
2. FUNDI	☐ NORMAL	☐ ABNORMAL	13. VAGINA	☐ NORMAL	☐ INFLAMMATION ☐ DISCHARGE
3. TEETH	☐ NORMAL	☐ ABNORMAL	14. CERVIX	☐ NORMAL	☐ INFLAMMATION ☐ LESIONS
4. THYROID	☐ NORMAL	☐ ABNORMAL	15. UTERUS SIZE	_____ WEEKS	☐ FIBROIDS
5. BREASTS	☐ NORMAL	☐ ABNORMAL	16. ADNEXA	☐ NORMAL	☐ MASS
6. LUNGS	☐ NORMAL	☐ ABNORMAL	17. RECTUM	☐ NORMAL	☐ ABNORMAL
7. HEART	☐ NORMAL	☐ ABNORMAL	18. DIAGONAL CONJUGATE	☐ REACHED	☐ NO _____ CM
8. ABDOMEN	☐ NORMAL	☐ ABNORMAL	19. SPINES	☐ AVERAGE	☐ PROMINENT ☐ BLUNT
9. EXTREMITIES	☐ NORMAL	☐ ABNORMAL	20. SACRUM	☐ CONCAVE	☐ STRAIGHT ☐ ANTERIOR
10. SKIN	☐ NORMAL	☐ ABNORMAL	21. SUBPUBIC ARCH	☐ NORMAL	☐ WIDE ☐ NARROW
11. LYMPH NODES	☐ NORMAL	☐ ABNORMAL	22. GYNECOID PELVIC TYPE	☐ YES	☐ NO

COMMENTS (Number and explain abnormals) _____

_____

_____ EXAM BY _____

Patient's Name: **Date of Birth:**

PHYSICAL EXAMINATION:

T. P. R. B.P. Hgt. Pres. Wt. Wt. at L.M.P.

Eyes Teeth Thyroid Throat Skin

Heart

Lungs

Breasts Nipples Tumors

Abdomen Height of Fundus

Fetal Heart Presentation and Position

Extremities Varicosities Edema

General Body Type

PELVIC EXAMINATION (bi-manual and speculum):

Vulva

Vagina

Perineum

Cervix

Uterus

Adnexae

Rectal Exam.

Diag. Conj. cm.	Trans. Diam. Outlet cm.	Shape Sacrum
Arch	Coccyx	S.-S. notch
Ischial Spines		

Inlet:	Mid Pelvis:	Outlet:	Prognosis for Delivery:
☐ Adequate	☐ Adequate	☐ Adequate	
☐ Borderline	☐ Borderline	☐ Borderline	
☐ Contracted	☐ Contracted	☐ Contracted	

LABORATORY EXAMINATIONS: For Syphilis Type Date Result

Blood Type and Rh: Patient Father of Child

Hemoglobin Hematocrit or RBC

Urinalysis: Albumin Sugar Microscopic

Exam. for Tbc: Type Date Result

(Cytology, Chemistry, etc.)

FACTS OF SPECIAL IMPORTANCE:
Initial Over-all Evaluation of Patient:

Sensitivities Nutritional Status

Type of Del. planned Anesthesia planned

Physician to call if attending M.D. not available

M.D. who will attend infant Is breast feeding planned?

Date Signed