



# ANTEPARTUM RECORD

Date: \_\_\_\_\_ ID #: \_\_\_\_\_

Hospital of Delivery: \_\_\_\_\_

Name: \_\_\_\_\_

LAST	FIRST	MIDDLE
Newborn Care Provider:		Referred By:
Primary Care Provider/Group:		Address:
Final EDD:		
Birth Date: _____	Age: _____	Race: _____
Marital Status: _____		Address: _____
S M W D Sep		Zip: _____ Phone: _____ (1) _____ (2)
Occupation: _____	Education: _____ (Last Grade Completed)	
Language: _____	Ethnicity: _____	Insurance Carrier/Medicaid #: _____
Partner: _____	Phone: _____	Policy #: _____
Father Of Baby: _____	Phone: _____	Emergency Contact: _____ Phone: _____
Total Preg: _____	Full Term: _____	Premature: _____
Ab, Induced: _____	Ab, Spontaneous: _____	Ectopic Pregnancy: _____
Multiple Births: _____		Living: _____

### Menstrual History

Lmp  Definite  Approximate (Month Known)  Unknown  Normal Amount/Duration  Final: \_\_\_\_\_

Duration: Q \_\_\_\_\_ Days      Frequency: Q \_\_\_\_\_ Days      Menarche: \_\_\_\_\_ (Age Onset)

Prior Menses: \_\_\_\_\_ Date      Contraception at pregnancy  Yes  No      Hcg + \_\_\_\_/\_\_\_\_/\_\_\_\_

### Past Pregnancies (Last Five)

Date Month/Year	GA Weeks	Length Of Labor	Birth Weight	Sex M/F	Type Of Delivery	Anes	Place Of Delivery	Breastfeeding Duration	Lactation Consult Needed Yes/No	Comments/Complications

### Medical History

	P*	F*	Detail Positive Remarks Include Date & Treatment	P*	F*	Detail Positive Remarks Include Date & Treatment	
A. Drug/Latex Allergies/ Reactions						17. Dermatologic Disorders	
B. Allergies (Food, Seasonal, Environmental)				18. Operations/Hospitalizations (Year & Reason)			
1. Neurologic/Epilepsy				19. Gyn Surgery (Year & Reason)			
2. Thyroid Dysfunction				20. Anesthetic Complications			
3. Breast Disease/Breast Surgery				21. History Of Blood Transfusions			
4. Pulmonary (TB, Asthma)				22. Infertility			
5. Heart Disease				23. Art (IVF Or FET)			
6. Hypertension				24. History of Abnormal Pap			
7. Cancer				25. History of STI			
8. Hematologic Disorders				26. Psychiatric Illness			
9. Anemia				27. Depression/Postpartum Depression			
10. Gastrointestinal Disorders				28. Trauma/Violence			<b>Prepreg</b> <b>Preg</b> <b># Years Use</b>
11. Hepatitis/Liver Disease				29. Tobacco (Smoked, Chewed, ENDS, Vaped) (AMT/Day)			
12. Kidney Disease/UTI				30. Alcohol (AMT/Wk)			
13. Deep Vein Thrombosis				31. Drug Use (Including Opioids) (Uses/Wk)			
14. Diabetes (Type 1 Or Type 2)				32. Polycystic Ovary Syndrome			
15. Gestational Diabetes			33. Other				
16. Autoimmune Disorders							

\*P= Personal, F= Family

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

Patient Name:	Birth Date: - -	ID No.:	Date: - -
---------------	-----------------	---------	-----------

Genetic Screening*					Teratogen Exposures Since LMP/Pregnancy			
Condition	Patient	Partner	Other	Relationship	Yes	No	Details/Date	
Congenital Heart Defect					Prescription Medications			
Neural Tube Defect					Over The Counter Medications			
Hemoglobinopathy Or Carrier					Alcohol			
Cystic Fibrosis					Illicit Drugs			
Chromosome Abnormality					Maternal Diabetes			HGB A1C
Tay-Sachs					<b>Other</b>			
Hemophilia					Uterine Anomaly/DES			
Intellectual Disability/Autism								
Recurrent Pregnancy Loss/Stillbirth								
Other Structural Birth Defect								
Other Genetic Disease (eg, PKU, Metabolic Disease, Muscular Dystrophy)								

\*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			Yes	No
1. Live with Someone with TB or Exposed to TB				6. HIV Infection			
2. Patient or Partner Has History of Genital Herpes				7. History Of Hepatitis			
3. Rash or Viral Illness Since Last Menstrual Period				8. Recent Travel History or Partner Travel Outside of Country			
4. Prior GBS-Infected Child				9. Recent Exposure to Zika Virus, Including by Partner. Assess at each prenatal visit. Check cdc.gov/zika for updates.			
5. History of STIs: (Check All That Apply) <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Chlamydia <input type="checkbox"/> HPV <input type="checkbox"/> Syphilis <input type="checkbox"/> PID				10. Other (See Comments)			

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

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

Immunizations	Yes (Month/Year)		No	If No, Vaccine Indicated?*	Immunizations	Yes (Month/Year)		No	If No, Vaccine Indicated?*
	___ / ___	___ / ___				___ / ___	___ / ___		
Tdap (Each pregnancy; as early in the 27-36-weeks-of-gestation window as possible)					Hepatitis A (When Indicated)				
Influenza <sup>†</sup> (Each pregnancy as soon as vaccine is available)					Hepatitis B (When Indicated)				
Varicella <sup>†</sup>					Meningococcal (When Indicated)				
MMR (Rubella-containing vaccine) <sup>†</sup>					Pneumococcal (When Indicated)				
HPV									

\*Yes/No and date to be administered

<sup>†</sup>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 HPV, MMR, and varicella vaccines postpartum if needed. The Tdap vaccine can be given postpartum if the woman has never received it as an adult and did not get it during pregnancy.

Initial Physical Examination							
Date: ___ / ___ / ___		BP/Prepregnancy Weight: _____		Height: _____		BMI: _____	
1. Heent	Normal	Abnormal	11. Vulva	Normal	Abnormal	Condyloma	Lesions
2. Teeth	Normal	Abnormal	12. Vagina	Normal	Abnormal	Inflammation	Discharge
3. Thyroid	Normal	Abnormal	13. Cervix	Normal	Abnormal	Inflammation	Lesions
4. Breasts	Normal	Abnormal	14. Uterus Size	Weeks			Fibroids
5. Lungs	Normal	Abnormal	15. Adnexa	Normal	Abnormal	Mass	
6. Heart	Normal	Abnormal	16. Rectum	Normal	Abnormal	Abnormal	
7. Abdomen	Normal	Abnormal	17. Clinical Pelvimetry	Concerns	No Concerns		
8. Extremities	Normal	Abnormal					
9. Skin	Normal	Abnormal					
10. Lymph Nodes	Normal	Abnormal					

COMMENTS (Number and explain abnormals): \_\_\_\_\_

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