

DATE _____

NAME _____
 LAST FIRST MIDDLE

ID# _____ HOSPITAL OF DELIVERY _____

NEWBORN'S PHYSICIAN _____ REFERRED BY _____

FINALEDD				PRIMARY PROVIDER / GROUP _____			
BIRTHDATE	AGE	RACE	MARITAL STATUS	ADDRESS			
OCCUPATION			S M W D SEP	EDUCATION			
<input type="checkbox"/> HOMEMAKER <input type="checkbox"/> OUTSIDE WORK <input type="checkbox"/> STUDENT Type of Work _____			(LAST GRADE COMPLETED)	ZIP	PHONE	(H)	(O)
HUSBAND / FATHER OF BABY			PHONE	EMERGENCY CONTACT		PHONE	
TOTAL PREG	FULL TERM	PREMATURE	AB. INDUCED	AB. SPONTANEOUS	MULTIPLE BIRTHS	ECTOPICS	LIVING

MENSTRUAL HISTORY

LMP DEFINITE APPROXIMATE (MONTH KNOWN) MENES MONTHLY YES NO FREQUENCY: Q _____ DAYS MENARCHE _____ (AGE ON SET)

UNKNOWN NORMAL AMOUNT / DURATION PRIOR MENES _____ DATE ON BC PAT CONCEPT YES NO hCG+ ____ / ____ / ____

FINAL _____

PAST PREGNANCIES (LAST SIX)

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

PAST MEDICAL HISTORY

	ONeg +Pos	DETAIL POSITIVE REMARKS INCLUDED DATE & TREATMENT		ONeg +Pos	DETAIL POSITIVE REMARKS INCLUDED DATE & TREATMENT	
1. DIABETES			16. D(Rh) SENSITIZED			
2. HYPERTENSION			17. PULMONARY (TB, ASTHMA)			
3. HEART DISEASE			18. ALLERGIES (DRUGS)			
4. AUTOIMMUNE DISORDER			19. BREAST			
5. KIDNEY DISEASE / UTI			20. GYN SURGERY			
6. NEUROLOGIC / EPILEPSY			21. OPERATION / HOSPITALIZATIONS (YEAR & REASON)			
7. PSYCHIATRIC				22. ANESTHETIC COMPLICATIONS		
8. HEPATITIS / LIVER DISEASE						23. HISTORY OF ABNORMAL PAP
9. VARICOSITIES / PHLEBITIS				24. UTERINE ANOMALY / DES		
10. THYROID DYSFUNCTION				25. INFERTILITY		
11. TRAUMA / DOMESTIC VIOLENCE				26. RELEVANT FAMILY HISTORY		
12. HISTORY OF BLOOD TRANSFUS				27. OTHER		
	AMT / DAY PREPREG	AMT / DAY PREPREG	# YEARS USE			
13. TOBACCO						
14. ALCOHOL						
15. STREET DRUGS						

COMMENTS: _____

SYMPTOMSSINCELMP

	YES	NO		YES	NO
1. PATIENT'S AGE (35 OR OLDER)			12. MENTAL RETARDATION/AUTISM		
2. THALASSEMIA (ITALIAN, GREEK, MEDITERRANEAN, OR ASIAN BACKGROUND) MCV < 80			IF YES, WAS PERSON TREATED FOR FRAGILE X?		
3. NEURAL TUBE DEFECT (MENINGOMYELOCELE, SPINA BIFIDA, OR ANENCEPHALY)			13. OTHER INHERITED GENETIC OR CHROMOSOMAL DISORDER		
4. CONGENITAL HEART DEFECT			14. MATERNAL METABOLIC DISORDER (EG. INSULIN DEPENDENT DIABETES, PKU)		
5. DOWNSYNDROME			15. PATIENT OR BABY'S FATHER HAD A CHILD WITH BIRTH DEFECTS NOT LISTED ABOVE		
6. TAY-SACHS (EG. JEWISH, CAJUN, FRENCH-CANADIAN)			16. RECURRENT PREGNANCY LOSS, OR STILLBIRTH		
7. SICKLE CELL DISEASE OR TRAIT (AFRICAN)			17. MEDICATIONS/STREET DRUGS/ALCOHOL SINCE LAST MENSTRUAL PERIOD		
8. HEMOPHILIA			IF YES, AGENT(S)		
9. MUSCULAR DYSTROPHY			18. ANY OTHER		
10. CYSTIC FIBROSIS					
11. HUNTINGTON CHOREA					

COMMENTS/COUNSELING _____

INFECTION HISTORY	YES	NO		YES	NO
1. HIGH RISK HEPATITIS B/IMMUNIZED?			4. RASH OR VIRAL ILLNESS SINCE LAST MENSTRUAL PERIOD		
2. LIVE WITH SOMEONE WITH TB OR EXPOSED TO TB			5. HISTORY OF STD. GC. CHLAMYDIA HPV. SYPHILIS		
3. PATIENT OR PARTNER HAS HISTORY OF GENITAL HERPES			6. OTHER (SEE COMMENTS)		

COMMENTS _____

INTERVIEWER'S SIGNATURE _____

INITIAL PHYSICAL EXAMINATION					
DATE	PREPREGNANCY WEIGHT		HEIGHT	BP	
1. HEENT	<input type="checkbox"/> NORMAL	<input type="checkbox"/> ABNORMAL	12. VULVA	<input type="checkbox"/> NORMAL	<input type="checkbox"/> ABNORMAL
2. FUNDI	<input type="checkbox"/> NORMAL	<input type="checkbox"/> ABNORMAL	13. VAGINA	<input type="checkbox"/> NORMAL	<input type="checkbox"/> ABNORMAL
3. TEETH	<input type="checkbox"/> NORMAL	<input type="checkbox"/> ABNORMAL	14. CERVIX	<input type="checkbox"/> NORMAL	<input type="checkbox"/> ABNORMAL
4. THYROID	<input type="checkbox"/> NORMAL	<input type="checkbox"/> ABNORMAL	15. UTERUS SIZE	<input type="checkbox"/> NORMAL	<input type="checkbox"/> ABNORMAL
5. BREASTS	<input type="checkbox"/> NORMAL	<input type="checkbox"/> ABNORMAL	16. ADNEXA	<input type="checkbox"/> NORMAL	<input type="checkbox"/> ABNORMAL
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"/> NORMAL	<input type="checkbox"/> ABNORMAL
8. ABDOMEN	<input type="checkbox"/> NORMAL	<input type="checkbox"/> ABNORMAL	19. SPINES	<input type="checkbox"/> NORMAL	<input type="checkbox"/> ABNORMAL
9. EXTREMITIES	<input type="checkbox"/> NORMAL	<input type="checkbox"/> ABNORMAL	20. SACRUM	<input type="checkbox"/> NORMAL	<input type="checkbox"/> ABNORMAL
10. SKIN	<input type="checkbox"/> NORMAL	<input type="checkbox"/> ABNORMAL	21. SUBPUBIC ARCH	<input type="checkbox"/> NORMAL	<input type="checkbox"/> ABNORMAL
11. LYMPH NODE	<input type="checkbox"/> NORMAL	<input type="checkbox"/> ABNORMAL	22. GYNECOD PELVIC TYPE	<input type="checkbox"/> NORMAL	<input type="checkbox"/> ABNORMAL

COMMENTS (Number and explain abnormalities) _____

EXAM BY _____

LABORATORY AND EDUCATION

INITIAL LABS	DATE	RESULT	REVIEWED
BLOODTYPE	___ / ___ / ___	A B AB O	
D(Rh)TYPE	___ / ___ / ___		
ANTIBODYSCREEN	___ / ___ / ___		
HCT/HGB	___ / ___ / ___	_____ % _____ g/dl	
PAPTEST	___ / ___ / ___	NORMAL/ABNORMAL/ _____	
RUBELLA	___ / ___ / ___		
VDRL	___ / ___ / ___		
URINECULTURE/SCREEN	___ / ___ / ___		
HBsAg	___ / ___ / ___		
HIVCOUNSELING/TESTING	___ / ___ / ___	<input type="checkbox"/> POS <input type="checkbox"/> NEG <input type="checkbox"/> DECLINED	
OPTIONAL LABS	DATE	RESULT	REVIEWED
HGBELECTROPHORESIS	___ / ___ / ___	AA AS SS AC SC AF Ta2	
PPD	___ / ___ / ___		
CHLAMYDIA	___ / ___ / ___		
GC	___ / ___ / ___		
TAY-SACHS	___ / ___ / ___		
OTHER	___ / ___ / ___		
8-18-WEEK LABS (WHEN INDICATED)	DATE	RESULT	REVIEWED
ULTRASOUND	___ / ___ / ___		
MSAFP/MULTIPLE MARKERS	___ / ___ / ___		
AMNIO/ CVS	___ / ___ / ___		
KARYOTYPE	___ / ___ / ___	46.XX OR 46.XY / OTHER	
AMNIOTIC FLUID (AFP)	___ / ___ / ___	NORMAL _____ ABNORMAL _____	
24-28-WEEK LABS (WHEN INDICATED)	DATE	RESULT	REVIEWED
HCT/HGB	___ / ___ / ___	_____ % _____ g/dl	
DIABETESSCREEN	___ / ___ / ___	_____ 1 HOUR	
GTT (IF SCREEN ABNORMAL)	___ / ___ / ___	_____ FBS _____ 1 HOUR _____ 2 HOUR _____ 3 HOUR	
D(Rh) ANTIBODY SCREEN	___ / ___ / ___		
DIMMUNE GLOBULIN (RhIG) GIVEN (28 WKS)	___ / ___ / ___	SIGNATURE _____	
32-36-WEEK LABS (WHEN INDICATED)	DATE	RESULT	REVIEWED
HCT/HGB (RECOMMENDED)	___ / ___ / ___	_____ % _____ g/dl	
ULTRASOUND	___ / ___ / ___		
VDRL	___ / ___ / ___		
GC	___ / ___ / ___		
CHLAMYDIA	___ / ___ / ___		
GROUP B STREP (35-37 WKS)	___ / ___ / ___		

COMMENTS/ADDITIONAL LABS

PLANS/EDUCATION (COUNSELED)

- ANESTHESIA PLANS _____
- TOXOPLASMOSIS PRECAUTIONS (CATS/RAW MEAT) _____
- CHILD BIRTH CLASSES _____
- PHYSICAL/SEXUAL ACTIVITY _____
- LABOR SIGNS _____
- NUTRITION COUNSELING _____
- BREAST OR BOTTLE FEEDING _____
- NEWBORN CARE SEAT _____
- POSTPARTUM BIRTH CONTROL _____
- ENVIRONMENTAL/WORK HAZARDS _____

- TUBAL STERILIZATION _____
- VS ACCOUNSELING _____
- CIRCUMCISION _____
- TRAVEL _____
- LIFESTYLE, TOBACCO, ALCOHOL _____

REQUESTS _____

TUBAL STERILIZATION DATE INITIALS
 CONSENTS SIGNED _____ / _____ / _____

PROVIDER SIGNATURE (AS REQUIRED) _____

