

DATE _____
 NAME _____
 LAST FIRST MIDDLE
 ID # _____ HOSPITAL OF DELIVERY _____
 NEWBORN'S PHYSICIAN _____ REFERRED BY _____

FINAL EDD _____		PRIMARY PROVIDER/GROUP _____					
BIRTH DATE MONTH DAY YEAR		AGE	RACE	MARITAL STATUS S M W D SEP		ADDRESS:	
OCCUPATION <input type="checkbox"/> HOMEMAKER <input type="checkbox"/> OUTSIDE WORK <input type="checkbox"/> STUDENT Type of Work _____		EDUCATION (LAST GRADE COMPLETED)		ZIP: _____ PHONE: _____ (H) _____ (O) _____		INSURANCE CARRIER/MEDICAID # _____	
HUSBAND/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: C _____ 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

PAST MEDICAL HISTORY

	O Neg + Pos.	DETAIL POSITIVE REMARKS INCLUDE DATE & TREATMENT	O Neg + Pos.	DETAIL POSITIVE REMARKS INCLUDE 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. OPERATIONS / 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 PREG	#YEARS USE	
13. TOBACCO				
14. ALCOHOL				
15. STREET DRUGS				

COMMENTS: _____

ACOG ANTEPARTUM RECORD (FORM A)

Patient Name _____ DOB _____

SYMPTOMS SINCE LMP

GENETIC SCREENING/TERATOLOGY COUNSELING INCLUDES PATIENT, BABY'S FATHER, OR ANYONE IN EITHER FAMILY WITH:					
	YES	NO		YES	NO
1. PATIENT'S AGE ≥ 35 YEARS			12. MENTAL RETARDATION/AUTISM		
2. THALASSEMIA (ITALIAN, GREEK, MEDITERRANEAN, OR ASIAN BACKGROUND); MCV < 80			IF YES, WAS PERSON TESTED 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. DOWN SYNDROME			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 A 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"/> CONDYLOMA	<input type="checkbox"/> LESIONS			
2. FUNDI	<input type="checkbox"/> NORMAL	<input type="checkbox"/> ABNORMAL	13. VAGINA	<input type="checkbox"/> NORMAL	<input type="checkbox"/> INFLAMMATION	<input type="checkbox"/> DISCHARGE			
3. TEETH	<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				
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 _____