

HAPPY FAMILY MIDWIFE CLINIC

(Birth Home & Family Planning)

Lower Jasaan, Misamis Oriental

(Contact Number: (08822) 760-041, cell# 09178859217)

PATIENT INFORMATION:

Date of Registration:	Family Serial Number:			PhilHealth (<input type="checkbox"/>) yes / (<input type="checkbox"/>) no PHC Number:
Last Name:	Given Name:			Middle Name:
Complete Address:		Age:	Civil Status:	
Birthday:	Birth Place:			Religion:
Occupation:	Blood Type:		Menarche:	Contact #:

PREGNANCY DETAILS:

Last Menstrual Period:	Expected Date of Confinement:	OB Score: G P (F P A L)
Risk Code		
<input type="checkbox"/> A= An age less than 18 or greater than 35, Date Detected: _____ <input type="checkbox"/> B= Being less than 145cm (4'9") tall; Date Detected: _____ <input type="checkbox"/> C= Delivered a fourth (or more) baby (or so called grandmulti); Date Detected: _____ <input type="checkbox"/> D = Having one or more of the ff. (a) previous CS (b) 3 consecutive miscarriages or stillborn baby and (c) postpartum hemorrhage Date Detected _____ <input type="checkbox"/> E= Having one or more of the ff medical conditions: (1)TB (2)Heart Disease (3)Diabetes (4)Bronchial Asthma (5)Goiter; Date Detected: _____		

OB HISTORY:

Gravida (year)	Facility Confined	AOG	Manner of Delivery	Presentation	Gender	Complications

ULTRASOUND AND LABORATORY RESULTS:

Date UTZ taken: _____	AOG: _____	EDC: _____
Presentation: _____	Remarks: _____	
Urine Analysis:	CBC Result:	Hep B Test: (+) / (-)

TETANUS TOXOID VACCINATION STATUS:

TT1: (<input type="checkbox"/>) _____	TT2: (<input type="checkbox"/>) _____	TT3: (<input type="checkbox"/>) _____	TT4: (<input type="checkbox"/>) _____	TT5: (<input type="checkbox"/>) _____
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PRENATAL VISITS:

Date & Time of 1st Prenatal Visit: <hr/> AOG: _____ Trimester: _____	Vital Signs: BP: _____ mmHg Temp.: _____ °C PR: _____ cpm RR: _____ bpm Weight: _____ kg. Fundic Height: _____ FHT: _____	Vitamins Taken:
Remarks:		

DELIVERY DETAILS:

Date and Time of Delivery:	Sex:	Birth Weight (grams):	Anthropometric Measurement: (in cm) CC: ____ AC: ____
Meds and Vaccine Given: <input type="checkbox"/> Vitamin K <input type="checkbox"/> Hep B <input type="checkbox"/> Credes			

POST PARTUM VISITS:

Date of 1st PP Visit:	Breast Feeding: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, Reason:	Supplementation:	Management/ Remarks:
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Date of 2nd PP Visit:	Breast Feeding: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, Reason:	Supplementation:	Management/ Remarks:
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