

## JIMIRENE DIAGNOSTIC & MATERNITY CLINIC

## BLK 22 LOT 17 PKG 2 PHASE 10A BAGONG SILANG CALOOCAN CITY CONTACT NOS. 09309206666 / 02 273-1394

						CLIENT NO:
Name of Clien	nt:					
	( Last n	( Last name)		ame)		(M.I.)
Address:			Religion:			
Age:		Birthday:			Occupation:	
Name of Spou			Religion:			
Age:	Birthday:	Birthday:			Occupation:	
Contact No:			_	Date	of last delivery:	
<u>MEDI</u>	Allergie Drug in	S No Smoking Allergies Drug intake			NUMBER OF P 01/R 2 3 4 a Gravida Para Term	
	Bleeding/ Anemia Diabetes / Congeni Previous Cesarean 3 Consecutive Misc Post Partum Hemo Forcep Delivery Pregnancy include		ection irriages rhage		Pre-Term Abortion Living LMP EDC TT date given Menarch:	
DATE	AOG	ВР	Wt	FH	FHT	REMARKS

Legend:

R- Refer to back up physician for clearance

R/H- Refer to hospital

Complaints: