Patient Addressograph

DATE _____

NAME _____
LAST FIRST MIDDLE

ID # _____ HOSPITAL OF DELIVERY _____

NEWBORN'S PHYSICIAN _____ REFERRED BY _____

PRIMARY PROVIDER/GROUP _____

FINAL EDD _____ ADDRESS _____

BIRTH DATE MONTH DAY YEAR AGE RACE MARITAL STATUS S M W D SEP	ADDRESS
OCCUPATION EDUCATION (LAST GRADE COMPLETED)	ZIP PHONE (H) (O)
LANGUAGE ETHNICITY	INSURANCE CARRIER/MEDICAID #
HUSBAND/DOMESTIC PARTNER PHONE	POLICY #
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: Q _____ 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

MEDICAL HISTORY

	○ Neg. + Pos.	DETAIL POSITIVE REMARKS INCLUDE DATE & TREATMENT
1. DIABETES		
2. HYPERTENSION		
3. HEART DISEASE		
4. AUTOIMMUNE DISORDER		
5. KIDNEY DISEASE/UTI		
6. NEUROLOGIC/EPILEPSY		
7. PSYCHIATRIC		
8. DEPRESSION/POSTPARTUM DEPRESSION		
9. HEPATITIS/LIVER DISEASE		
10. VARICOSITIES/PHLEBITIS		
11. THYROID DYSFUNCTION		
12. TRAUMA/VIOLENCE		
13. HISTORY OF BLOOD TRANSFUS.		

	AMT/DAY PREPREG	AMT/DAY PREG	# YEARS USE
14. TOBACCO			
15. ALCOHOL			
16. ILLICIT/RECREATIONAL DRUGS			

	○ Neg. + Pos.	DETAIL POSITIVE REMARKS INCLUDE DATE & TREATMENT
17. D (Rh) SENSITIZED		
18. PULMONARY (TB, ASTHMA)		
19. SEASONAL ALLERGIES		
20. DRUG/LATEX ALLERGIES/ REACTIONS		
21. BREAST		
22. GYN SURGERY		
23. OPERATIONS/ HOSPITALIZATIONS (YEAR & REASON)		
24. ANESTHETIC COMPLICATIONS		
25. HISTORY OF ABNORMAL PAP		
26. UTERINE ANOMALY/DES		
27. INFERTILITY		
28. ART TREATMENT		
29. RELEVANT FAMILY HISTORY		
30. OTHER		

COMMENTS _____

ACOG ANTEPARTUM RECORD (FORM A)

 AA128 12345/10987

SYMPTOMS SINCE LMP

GENETIC SCREENING/TERATOLOGY COUNSELING

INCLUDES PATIENT, BABY'S FATHER, OR ANYONE IN EITHER FAMILY WITH:

	YES	NO
1. PATIENT'S AGE 35 YEARS OR OLDER AS OF ESTIMATED DATE OF DELIVERY		
2. THALASSEMIA (ITALIAN, GREEK, MEDITERRANEAN, OR ASIAN BACKGROUND): MCV LESS THAN 80		
3. NEURAL TUBE DEFECT (MENINGOMYELOCELE, SPINA BIFIDA, OR ANENCEPHALY)		
4. CONGENITAL HEART DEFECT		
5. DOWN SYNDROME		
6. TAY–SACHS (ASHKENAZI JEWISH, CAJUN, FRENCH CANADIAN)		
7. CANAVAN DISEASE (ASHKENAZI JEWISH)		
8. FAMILIAL DYSAUTONOMIA (ASHKENAZI JEWISH)		
9. SICKLE CELL DISEASE OR TRAIT (AFRICAN)		
10. HEMOPHILIA OR OTHER BLOOD DISORDERS		
11. MUSCULAR DYSTROPHY		
12. CYSTIC FIBROSIS		

	YES	NO
13. HUNTINGTON'S CHOREA		
14. MENTAL RETARDATION/AUTISM		
IF YES, WAS PERSON TESTED FOR FRAGILE X?		
15. OTHER INHERITED GENETIC OR CHROMOSOMAL DISORDER		
16. MATERNAL METABOLIC DISORDER (EG, TYPE 1 DIABETES, PKU)		
17. PATIENT OR BABY'S FATHER HAD A CHILD WITH BIRTH DEFECTS NOT LISTED ABOVE		
18. RECURRENT PREGNANCY LOSS, OR A STILLBIRTH		
19. MEDICATIONS (INCLUDING SUPPLEMENTS, VITAMINS, HERBS OR OTC DRUGS)/ILLICIT/RECREATIONAL DRUGS/ALCOHOL SINCE LAST MENSTRUAL PERIOD		
IF YES, AGENT(S) AND STRENGTH/DOSAGE		
20. ANY OTHER		

COMMENTS/COUNSELING _____

_____

INFECTION HISTORY	YES	NO
1. LIVE WITH SOMEONE WITH TB OR EXPOSED TO TB		
2. PATIENT OR PARTNER HAS HISTORY OF GENITAL HERPES		
3. RASH OR VIRAL ILLNESS SINCE LAST MENSTRUAL PERIOD		

4. HEPATITIS B, C	YES ☐ NO ☐
5. HISTORY OF STD, GONORRHEA, CHLAMYDIA, HPV, HIV, SYPHILIS (CIRCLE ALL THAT APPLY)	
6. OTHER (SEE COMMENTS)	

COMMENTS _____

_____ **INTERVIEWER'S SIGNATURE** _____

INITIAL PHYSICAL EXAMINATION

DATE _____ / _____ / _____ WEIGHT _____ HEIGHT _____ BMI _____ BP_____

1. HEENT	☐ NORMAL	☐ ABNORMAL	12. VULVA	☐ NORMAL	☐ CONDYLOMA	☐ LESIONS
2. FUNDI	☐ NORMAL	☐ ABNORMAL	13. VAGINA	☐ NORMAL	☐ INFLAMMATION	☐ DISCHARGE
3. TEETH	☐ NORMAL	☐ ABNORMAL	14. CERVIX	☐ NORMAL	☐ INFLAMMATION	☐ LESIONS
4. THYROID	☐ NORMAL	☐ ABNORMAL	15. UTERUS SIZE	_____ WEEKS		☐ FIBROIDS
5. BREASTS	☐ NORMAL	☐ ABNORMAL	16. ADNEXA	☐ NORMAL	☐ MASS	
6. LUNGS	☐ NORMAL	☐ ABNORMAL	17. RECTUM	☐ NORMAL	☐ ABNORMAL	
7. HEART	☐ NORMAL	☐ ABNORMAL	18. DIAGONAL CONJUGATE	☐ REACHED	☐ NO	_____ CM
8. ABDOMEN	☐ NORMAL	☐ ABNORMAL	19. SPINES	☐ AVERAGE	☐ PROMINENT	☐ BLUNT
9. EXTREMITIES	☐ NORMAL	☐ ABNORMAL	20. SACRUM	☐ CONCAVE	☐ STRAIGHT	☐ ANTERIOR
10. SKIN	☐ NORMAL	☐ ABNORMAL	21. SUBPUBIC ARCH	☐ NORMAL	☐ WIDE	☐ NARROW
11. LYMPH NODES	☐ NORMAL	☐ ABNORMAL	22. GYNECOID PELVIC TYPE	☐ YES	☐ NO	

COMMENTS (Number and explain abnormals) _____

_____

_____ **EXAM BY** _____

Patient Addressograph

NAME _____
LAST FIRST MIDDLE

DRUG ALLERGY_____ | LATEX ALLERGY ☐ YES ☐ NO

IS BLOOD TRANSFUSION ACCEPTABLE? ☐ YES ☐ NO | ANTEPARTUM ANESTHESIA CONSULT PLANNED ☐ YES ☐ NO

PROBLEMS/PLANS	**MEDICATION LIST** (Include Dosage)	Start date	Stop date
1.	1.	____/____/____	____/____/____
2.	2.	____/____/____	____/____/____
3.	3.	____/____/____	____/____/____
4.	4.	____/____/____	____/____/____
5.	5.	____/____/____	____/____/____
6.	6.	____/____/____	____/____/____

EDD CONFIRMATION

INITIAL EDD
LMP ____/____/____ = EDD ____/____/____
INITIAL EXAM ____/____/____ = ____ WKS = EDD ____/____/____
ULTRASOUND ____/____/____ = ____ WKS = EDD ____/____/____
INITIAL EDD ____/____/____ INITIALED BY _____

18–20-WEEK EDD UPDATE

QUICKENING ____/____/____ +22 WKS = ____/____/____
FUNDAL HT. AT UMBIL. ____/____/____ +20 WKS = ____/____/____
ULTRASOUND ____/____/____ = ____ WKS = ____/____/____
FINAL EDD ____/____/____ INITIALED BY _____

PREPREGNANCY WEIGHT
_____

WEEKS GEST. (BEST EST.)	FUNDAL HEIGHT (CM)	PRESENTATION	FHR	FETAL MOVEMENT	PRETERM LABOR SIGNS/SYMPTOMS: +=PRESENT ○=ABSENT	CERVIX EXAM (DIL./EFF. STA.) ULTRASOUND LENGTH	BLOOD PRESSURE	WEIGHT	URINE (ALBUMIN/GLUCOSE)	EDEMA	PAIN SCALE* (0-10)	NEXT APPOINTMENT	PROVIDER (INITIALS)	COMMENTS

PROBLEMS _____

COMMENTS _____

*Describe the intensity of discomfort ranging from 0 (no pain) to 10 (worst possible pain).

ACOG ANTEPARTUM RECORD (FORM C)

LABORATORY AND EDUCATION

INITIAL LABS	DATE	RESULT	REVIEWED
BLOOD TYPE	/ /	A B AB O	
D (Rh) TYPE	/ /		
ANTIBODY SCREEN	/ /		
HCT/HGB/MCV	/ /	_____ % _____ g/dL	
PAP TEST	/ /	NORMAL/ABNORMAL/_____	
VARICELLA			
RUBELLA	/ /		
VDRL	/ /		
URINE CULTURE/SCREEN	/ /		
HBsAg	/ /		
HIV COUNSELING/TESTING*	/ /	POS. NEG. DECLINED	
OPTIONAL LABS	**DATE**	**RESULT**	
HEMOGLOBIN ELECTROPHORESIS	/ /	AA AS SS AC SC AF $\uparrow A_2$ POS. NEG. DECLINED	
PPD	/ /		
CHLAMYDIA	/ /		
GONORRHEA	/ /		
CYSTIC FIBROSIS	/ /	POS. NEG. DECLINED	
TAY-SACHS	/ /	POS. NEG. DECLINED	
FAMILIAL DYSAUTONOMIA	/ /	POS. NEG. DECLINED	
HEMOGLOBIN			
GENETIC SCREENING TESTS (SEE FORM B)	/ /		
OTHER			
8–20-WEEK LABS (WHEN INDICATED/ ELECTED)	**DATE**	**RESULT**	
ULTRASOUND	/ /		
1ST TRIMESTER ANEUPLOIDY RISK ASSESSMENT	/ /	POS. NEG. DECLINED	
MSAFP/MULTIPLE MARKERS	/ /	POS. NEG. DECLINED	
2ND TRIMESTER SERUM SCREENING	/ /	POS. NEG. DECLINED	
AMNIO/CVS	/ /		
KARYOTYPE	/ /	46,XX OR 46,XY/OTHER_____	
AMNIOTIC FLUID (AFP)	/ /	NORMAL____ ABNORMAL____	
ANTI-D IMMUNE GLOBULIN (RHIG)	/ /		

COMMENTS/ADDITIONAL LABS

*Check state requirements before recording results.

(CONTINUED)

PROVIDER SIGNATURE (AS REQUIRED) _____

LABORATORY AND EDUCATION *(continued)*

24–28-WEEK LABS (WHEN INDICATED)	**DATE**	**RESULT**		**COMMENTS/ADDITIONAL LABS**
HCT/HGB/MCV	/ /	_____ % _____ g/dL		
DIABETES SCREEN	/ /	1 HOUR_____		
GTT (IF SCREEN ABNORMAL)	/ /	_____FBS _____1 HOUR _____2 HOUR _____3 HOUR		
D (Rh) ANTIBODY SCREEN	/ /			
ANTI-D IMMUNE GLOBULIN (RhIG) GIVEN (28 WKS OR GREATER)	/ /	SIGNATURE _____		
32–36-WEEK LABS	**DATE**	**RESULT**		
HCT/HGB	/ /	_____ % _____ g/dL		
ULTRASOUND (WHEN INDICATED)	/ /			
HIV (WHEN INDICATED)*				
VDRL (WHEN INDICATED)	/ /			
GONORRHEA (WHEN INDICATED)	/ /			
CHLAMYDIA (WHEN INDICATED)	/ /			
GROUP B STREP	/ /			

*Check state requirements before recording results.

COMMENTS

PROVIDER SIGNATURE (AS REQUIRED) _____

Patient Addressograph

NAME _____
LAST FIRST MIDDLE

PLANS/EDUCATION
(COUNSELED ☐)—BY TRIMESTER. INITIAL AND DATE WHEN DISCUSSED.

FIRST TRIMESTER	**COMPLETED**	**NEED FOR FURTHER DISCUSSION**
☐ HIV AND OTHER ROUTINE PRENATAL TESTS		☐ FOLLOW-UP IN 3RD TRIMESTER, IF NEEDED
☐ RISK FACTORS IDENTIFIED BY PRENATAL HISTORY		
☐ ANTICIPATED COURSE OF PRENATAL CARE		
☐ NUTRITION AND WEIGHT GAIN COUNSELING; SPECIAL DIET		
☐ TOXOPLASMOSIS PRECAUTIONS (CATS/RAW MEAT)		
☐ SEXUAL ACTIVITY		
☐ EXERCISE		
☐ INFLUENZA VACCINE		
☐ SMOKING COUNSELING		
☐ ENVIRONMENTAL/WORK HAZARDS		
☐ TRAVEL		
☐ TOBACCO (ASK, ADVISE, ASSESS, ASSIST, AND ARRANGE)		
☐ ALCOHOL		
☐ ILLICIT/RECREATIONAL DRUGS		
☐ USE OF ANY MEDICATIONS (INCLUDING SUPPLEMENTS, VITAMINS, HERBS, OR OTC DRUGS)		
☐ INDICATIONS FOR ULTRASOUND		
☐ DOMESTIC VIOLENCE		
☐ SEAT BELT USE		
☐ CHILDBIRTH CLASSES/HOSPITAL FACILITIES		
SECOND TRIMESTER		
☐ SIGNS AND SYMPTOMS OF PRETERM LABOR		
☐ ABNORMAL LAB VALUES		
☐ INFLUENZA VACCINE		
☐ SELECTING A NEWBORN CARE PROVIDER		
☐ SMOKING COUNSELING		
☐ DOMESTIC VIOLENCE		
☐ POSTPARTUM FAMILY PLANNING/TUBAL STERILIZATION		

(CONTINUED)

COMMENTS

PLANS/EDUCATION *(continued)*
(COUNSELED ☐)—BY TRIMESTER. INITIAL AND DATE WHEN DISCUSSED.

THIRD TRIMESTER	COMPLETED	NEED FOR FURTHER DISCUSSION
☐ ANESTHESIA/ANALGESIA PLANS		
☐ FETAL MOVEMENT MONITORING		
☐ LABOR SIGNS		
☐ VBAC COUNSELING		
☐ SIGNS AND SYMPTOMS OF PREGNANCY-INDUCED HYPERTENSION		
☐ POSTTERM COUNSELING		
☐ CIRCUMCISION		
☐ BREAST OR BOTTLE FEEDING		
☐ POSTPARTUM DEPRESSION		
☐ INFLUENZA VACCINE		
☐ SMOKING COUNSELING		
☐ DOMESTIC VIOLENCE		
☐ NEWBORN EDUCATION (NEWBORN SCREENING, JAUNDICE, SIDS, CAR SEAT)		
☐ FAMILY MEDICAL LEAVE OR DISABILITY FORMS		

REQUESTS

TUBAL STERILIZATION CONSENT SIGNED DATE ___/___/___ INITIALS _____

HISTORY AND PHYSICAL HAVE BEEN SENT TO HOSPITAL, IF APPLICABLE. DATE ___/___/___ INITIALS _____

COMMENTS

Plans/Education Notes

Patient Addressograph

NAME _____
LAST FIRST MIDDLE

ID # _____

EDD _____

Supplemental Visits

PREPREGNANCY WEIGHT

_____

WEEKS GEST. (BEST EST.)	FUNDAL HEIGHT (CM)	PRESENTATION	FHR	FETAL MOVEMENT	PRETERM LABOR SIGNS/SYMPTOMS; +=PRESENT O=ABSENT	CERVIX EXAM (DIL./EFF; STA.) ULTRASOUND LENGTH	BLOOD PRESSURE	WEIGHT	URINE (ALBUMIN/GLUCOSE)	EDEMA	PAIN SCALE* (0-10)	NEXT APPOINTMENT	PROVIDER (INITIALS)	COMMENTS

*Describe the intensity of discomfort ranging from 0 (no pain) to 10 (worst possible pain).

Progress Notes

PROVIDER SIGNATURE (AS REQUIRED) _____

Patient Addressograph

NAME _____
LAST FIRST MIDDLE

ID # _____

EDD _____

Supplemental Visits

PREPREGNANCY WEIGHT

_____

WEEKS GEST. (BEST EST.)	FUNDAL HEIGHT (CM)	PRESENTATION	FHR	FETAL MOVEMENT	PRETERM LABOR SIGNS/SYMPTOMS: +=PRESENT O=ABSENT	CERVIX EXAM (DIL./EFF. STA.) ULTRASOUND LENGTH	BLOOD PRESSURE	WEIGHT	URINE (ALBUMIN/GLUCOSE)	EDEMA	PAIN SCALE* (0-10)	NEXT APPOINTMENT	PROVIDER (INITIALS)

COMMENTS

*Describe the intensity of discomfort ranging from 0 (no pain) to 10 (worst possible pain).

Progress Notes

PROVIDER SIGNATURE (AS REQUIRED) _____

Patient Addressograph

NAME _____
LAST FIRST MIDDLE

ID # _____

Progress Notes

PROVIDER SIGNATURE (AS REQUIRED) _____

Patient Addressograph

NAME _____
LAST FIRST MIDDLE

ID # _____

Progress Notes

PROVIDER SIGNATURE (AS REQUIRED) _____