CHIEF COMPLAINT,: This 32 year-old female presents today for an initial obstetrical examination. Home pregnancy test was positive.,The patient indicates fetal activity is not yet detected (due to early stage of pregnancy). LMP: 02/13/2002 EDD: 11/20/2002 GW: 8.0 weeks. Patient has been trying to conceive for 6 months.,Menses: Onset: 12 years old. Interval: 24-26 days. Duration: 4-6 days. Flow: moderate. Complications: PMS - mild.,Last Pap smear taken on 11/2/2001. Contraception: Patient is currently using none.,ALLERGIES:, Patient admits allergies to venom - bee/wasp resulting in difficulty breathing, severe rash, pet dander resulting in nasal stuffiness. Medication History: None.,PAST MEDICAL HISTORY:, Past medical history is unremarkable. Past Surgical History: Patient admits past surgical history of tonsillectomy in 1980. Social History: Patient admits alcohol use Drinking is described as social, Patient denies illegal drug use, Patient denies STD history, Patient denies tobacco use.,FAMILY HISTORY:, Patient admits a family history of cancer of breast associated with mother.,REVIEW OF SYSTEMS:,Neurological: (+) unremarkable.,Respiratory: (+) difficulty sleeping, (-) breathing difficulties, respiratory symptoms.,Psychiatric: (+) anxious feelings.,Cardiovascular: (-) cardiovascular problems or chest symptoms.,Genitourinary: (-) decreased libido, (-) vaginal dryness, (-) vaginal bleeding. Diet is high in empty calories, high in fats and low in fiber.,PHYSICAL EXAM:, BP Standing: 126/84 Resp: 22 HR: 78 Temp: 99.1 Height: 5 ft. 6 in. Weight: 132 lbs.,Pre-Gravid Weight is 125 lbs.,Patient is a 32 year old

female who appears pleasant, in no apparent distress, her given age, well developed,,well nourished and with good attention to hygiene and body habitus.,Oriented to person, place and time.,Mood and affect normal and appropriate to situation.,HEENT:Head & Face: Examination of head and face is unremarkable.,Skin: No skin rash, subcutaneous nodules, lesions or ulcers observed. No edema observed.,Cardiovascular: Heart auscultation reveals no murmurs, gallop, rubs or clicks.,Respiratory: Lungs CTA.,Breast: Chest (Breasts): Breast inspection and palpation shows no abnormal findings.,Abdomen: Abdomen soft, nontender, bowel sounds present x 4 without palpable masses.,Genitourinary: External genitalia are normal in appearance. Examination of urethra shows no abnormalities. Examination of vaginal vault reveals no abnormalities. Cervix shows no pathology. Uterine portion of bimanual exam reveals contour normal, shape regular and size normal. Adnexa and parametria show no masses, tenderness, organomegaly or nodularity. Examination of anus and perineum shows no abnormalities.,TEST RESULTS: , Urine pregnancy test: positive. CBC results within normal limits. Blood type: O positive. Rh: positive. FBS: 88 mg/dl.,IMPRESSION:, Pregnancy, normal first. Maternal nutrition is inadequate for protein and poor and high in empty calories and junk foods and sweets.,PLAN:, Pap smear submitted for manual screening. Ordered CBC. Ordered blood type. Ordered hemoglobin. Ordered Rh.,Ordered fasting blood glucose.,COUNSELING:, Counseling was given regarding

adverse effects of alcohol, physical activity and sexual activity. Educational supplies dispensed to patient.,Return to clinic in 4 week (s).,PRESCRIPTIONS:, NatalCare Plus Dosage: Prenatal Multivitamins tablet Sig: QD Dispense: 60 Refills: 4 Allow Generic: Yes,PATIENT INSTRUCTIONS:, Patient received written information regarding pre-eclampsia and eclampsia. Patient was instructed to restrict activity. Patient instructed to limit caffeine use. Patient instructed to limit salt intake.