Well-Family MIDWIFE CLINIC

MATERNAL SERVICE RECORD

WFMC Form 2-A

Client Number: _____
Name of Client: _____ Last Name _____ Given Name _____ MI _____ Date of Birth _____ Occupation _____ No./Street _____ Barangay _____ Municipality _____ Province _____
Educational Background: _____ Address: _____ Contact Number: _____
Person to notify in case of emergency: _____
Date and Time of Arrival: _____ Time of Disposition: _____
Plan More Children: ___ YES ___ NO Current Use: ___ YES ___ NO Previous Use: ___ YES ___ NO
FP METHOD USED: ___ VSS ___ IUD ___ PIll ___ DMPA ___ NFP ___ LAM ___ Condom Others; specify: _____

MEDICAL HISTORY

HEENT
- N☐Y/R ☐ Epilepsy/Convulsion
- N☐Y/R ☐ Severe headache/dizziness
- N☐Y/R ☐ Visual disturbance
- N☐Y/R ☐ Yellowish discoloration
- N☐Y/R ☐ Enlarged thyroid

CHEST/HEART
- N☐Y/R ☐ Severe chest pain
- N☐Y/R ☐ Shortness of breath and easy fatigability
- N☐Y/R ☐ Breast/axillary masses
- N☐Y/R ☐ Nipple discharge (blood or pus)
- N☐Y/R ☐ Systolic of 140 and above
- N☐Y/R ☐ Diastolic of 90 and above
- N☐Y/R ☐ Family history of CVA (strokes), hypertension, asthma, rheumatic heart disease

ABDOMEN
- N☐Y/R ☐ Mass in the abdomen
- N☐Y/R ☐ History of gallbladder disease
- N☐Y/R ☐ History of liver disease
- N☐Y/R ☐ Previous surgical operation

EXTREMITIES
- N☐Y/R ☐ Severe varicosities
- N☐Y/R ☐ Deformities
- N☐Y/R ☐ Swelling of severe pain in the legs not related to injuries

SKIN
- N☐Y/R ☐ Yellowish discoloration

HISTORY OF ANY OF THE FF:
- N☐Y/R ☐ Smoking
- N☐Y/R ☐ Allergies
- N☐Y/R ☐ Drug intake
- N☐Y/R ☐ Drug abuse and alcoholism
- N☐Y/R ☐ STD, multiple partners
- N☐Y/R ☐ Bleeding tendencies, anemia
- N☐Y/R ☐ Diabetes/congenital anomalies

OBSTETRICAL HISTORY

0 1/R 2 3 4 and above/R/H

___	_Fullterm
___	_Preterm
___	_Abortion
___	_Living Children
_	_Date of last delivery (M/D/YR)
_	_Type of last delivery
_	_Past Menstrual Period
_	_Last Menstrual Period
___	_Age of gestation in weeks (AOG)
_	_Expected Date of Confinement (EDC)

HISTORY OF ANY OF THE FF:
- N☐Y/R ☐ Previous Cesarean Section
- N☐Y/R ☐ 3 Consecutive Miscarriages
- N☐Y/R ☐ Ectopic Pregnancy/H.mole
- N☐Y/R ☐ Postpartum hemorrhage
- N☐Y/R ☐ Forceps delivery
- N☐Y/R ☐ Pregnancy Induced Hypertension
- N☐Y/R ☐ Weight of baby > 4kgs

PHYSICAL EXAMINATION

Blood Pressure: _____ Height: _____
Weight: _____ Blood Type: _____

CONJUCTIVA
- N☐Y/R ☐ Pale
- N☐Y/R ☐ Yellowish

NECK
- N☐Y/R ☐ Enlarged Thyroid
- N☐Y/R ☐ Enlarged lymph nodes

BREAST
- N☐Y/R ☐ Mass
- N☐Y/R ☐ Nipple discharge
- N☐Y/R ☐ Skin-orange-peel or dimpling
- N☐Y/R ☐ Enlarged axillary lymph nodes

THORAX
- N☐Y/R ☐ Abnormal heart sounds/cardiac rate
- N☐Y/R ☐ Abnormal health sounds/respiratory rate

ABDOMEN
- _Fundic height in cms.
- _Fetal heart tone (if applicable by AOG)
- _Fetal movement

LEOPOLD'S MANEUVER
1. fetal part in the fundus
2. position of fetal back
3. presenting part
4. status of the presenting part

_Uterine Activity

PELVIC EXAMINATION

Perineum
- N☐Y/R ☐ Scars
- N☐Y/R ☐ Warts/mass
- N☐Y/R ☐ Laceration
- N☐Y/R ☐ Severe varicosities

Vagina
- N☐Y/R ☐ Bartholin's cyst
- N☐Y/R ☐ Warts/Skene's gland discharge
- N☐Y/R ☐ Cystocele/rectocele
- N☐Y/R ☐ Purulent discharge/bleeding
- N☐Y/R ☐ Erosion/polyp/foreign body

INTERNAL EXAMINATION

Cervix
- _Consistency - firm or soft
- _Dilatation
- _Palpable presenting part
- _Status of bag of water

IMPRESSION:

PLANS (Procedure/Treatment/Referral/Return Visit):

_____
Signature of Service Provider

Legend

R	Refer to Back-up Physician for clearance	**N**	No/Absent
R/H	Refer to a Hospital	**Y**	Yes/Present

Birth and Emergency Plan

I know that any complication can develop during delivery and I know that I should deliver in a health facility.

I will be attended at delivery by _____.

I plan to deliver at _____ .

This is a PhilHealth accredited facility ☐ Yes ☐ No

The estimated cost of the maternity package in this facility is _____ .

The mode of payment is cash.

The available transport is_____ .

I have contacted _____ to bring me to the hospital/ health center.

I will be accompanied by _____.

_____ will take care of my children/ home while I am in the health facility.

In case of a need for blood transfusion, my possible donors are:

- _____
- _____

In case of complications, I will be referred right away to:

_____

Person to notify in case of emergency:

Name and Relationship: _____

Address: _____

Contact Number/s: _____

_____

Patient's Signature Over Printed Name