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: ____ Time of Disposition: ____

Date and Time of Arrival: ____ Previous Use: ___ YES ___ NO

Plan More Children: ___ YES ___ NO Current Use: ___ YES ___ NO Condom Others; specify: ____

FP METHOD USED: ___ VSS ___ IUD ___ PILL ___ DMPA ___ NFP ___ LAM

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

___ 2	Fullterm
___ 0	Preterm
___ 0	Abortion
___ 2	Living Children
01-07-2000	Date of last delivery (M/D/YR)
CESAREAN	Type of last delivery
01-11-2000	Past Menstrual Period
12-01-2024	Last Menstrual Period
___ 4	Age of gestation in weeks (AOG)
01-01-2025	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: 120/180 Height: 100.99

Weight: - 61.5 Blood Type: - B+

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

10.0	Fundic height in cms.
12	Fetal heart tone (if applicable by AOG)
PRESENT	Fetal movement

LEOPOLD'S MANEUVER

HEAD	1. fetal part in the fundus
LEFT	2. position of fetal back
BUTTOCKS	3. presenting part
ENGAGED	4. status of the presenting part
REGULAR	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

FIRM	Consistency - firm or soft
8	Dilatation
HEAD	Palpable presenting part
INTACT	Status of bag of water

IMPRESSION:

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

UNDECIDED.

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 SANA MINATOZAKI.

I plan to deliver at WELL-FAMILY MIDWIFE CLINIC .

This is a PhilHealth accredited facility ☒ Yes ☐ No

The estimated cost of the maternity package in this facility is 5,000 .

The mode of payment is cash.

The available transport is AMBULANCE .

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

I will be accompanied by JEON JUNGKOOK .

JUNG HOSEOK 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:

- RUBY
- ALTER EGO

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

MACTAN DOCTOR'S HOSPITAL

Person to notify in case of emergency:

Name and Relationship: CARCEL H. ESCALANTE

Address: PAJAC, LAPU-LAPU CITY, CEBU

Contact Number/s: 09235670987

INES B. ESCALANTE

Patient's Signature Over Printed Name