Patient Addressograph

DATE _____

NAME _____
LAST FIRST MIDDLE

ID # _____ HOSPITAL OF DELIVERY _____

NEWBORN'S PHYSICIAN _____ REFERRED BY _____

FINAL EDD _____ PRIMARY PROVIDER/GROUP _____

BIRTH DATE AGE RACE MARITAL STATUS MONTH DAY YEAR S M W D SEP	ADDRESS
OCCUPATION EDUCATION (LAST GRADE COMPLETED)	ZIP PHONE (H) (O)
LANGUAGE	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. RELEVANT FAMILY HISTORY		
29. OTHER		

COMMENTS _____

ACOG ANTEPARTUM RECORD (FORM A)

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Patient Addressograph

SYMPTOMS SINCE LMP

GENETIC SCREENING/TERATOLOGY COUNSELING

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

	YES	NO		YES	NO
1. PATIENT'S AGE ≥ 35 YEARS AS OF ESTIMATED DATE OF DELIVERY			12. HUNTINGTON'S CHOREA		
2. THALASSEMIA (ITALIAN, GREEK, MEDITERRANEAN, OR ASIAN BACKGROUND): MCV <80			13. MENTAL RETARDATION/AUTISM		
3. NEURAL TUBE DEFECT (MENINGOMYELOCELE, SPINA BIFIDA, OR ANENCEPHALY)			IF YES, WAS PERSON TESTED FOR FRAGILE X?		
4. CONGENITAL HEART DEFECT			14. OTHER INHERITED GENETIC OR CHROMOSOMAL DISORDER		
5. DOWN SYNDROME			15. MATERNAL METABOLIC DISORDER (EG, TYPE 1 DIABETES, PKU)		
6. TAY–SACHS (EG, JEWISH, CAJUN, FRENCH CANADIAN)			16. PATIENT OR BABY'S FATHER HAD A CHILD WITH BIRTH DEFECTS NOT LISTED ABOVE		
7. CANAVAN DISEASE			17. RECURRENT PREGNANCY LOSS, OR A STILLBIRTH		
8. SICKLE CELL DISEASE OR TRAIT (AFRICAN)			18. MEDICATIONS (INCLUDING SUPPLEMENTS, VITAMINS, HERBS OR OTC DRUGS)/ILLICIT/RECREATIONAL DRUGS/ALCOHOL SINCE LAST MENSTRUAL PERIOD		
9. HEMOPHILIA OR OTHER BLOOD DISORDERS			IF YES, AGENT(S) AND STRENGTH/DOSAGE		
10. MUSCULAR DYSTROPHY					
11. CYSTIC FIBROSIS			19. ANY OTHER		

COMMENTS/COUNSELING _____

_____

_____

INFECTION HISTORY	YES	NO		YES	NO
1. LIVE WITH SOMEONE WITH TB OR EXPOSED TO TB			4. HISTORY OF STD, GONORRHEA, CHLAMYDIA, HPV, SYPHILIS		
2. PATIENT OR PARTNER HAS HISTORY OF GENITAL HERPES					
3. RASH OR VIRAL ILLNESS SINCE LAST MENSTRUAL PERIOD			5. OTHER (See Comments)		

COMMENTS _____

_____

_____ **INTERVIEWER'S SIGNATURE** _____

INITIAL PHYSICAL EXAMINATION

DATE _____ / _____ / _____ HEIGHT _____ 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** _____

ACOG ANTEPARTUM RECORD (FORM B)

Patient Addressograph

NAME _____
LAST FIRST MIDDLE

DRUG ALLERGY	LATEX ALLERGY

IS BLOOD TRANSFUSION ACCEPTABLE IN AN EMERGENCY? ☐ YES ☐ NO

ANESTHESIA CONSULT PLANNED ☐ YES ☐ NO

PROBLEMS/PLANS

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

MEDICATION LIST Start date Stop date

1. _____ ____/____/____ ____/____/____
2. _____ ____/____/____ ____/____/____
3. _____ ____/____/____ ____/____/____
4. _____ ____/____/____ ____/____/____
5. _____ ____/____/____ ____/____/____
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 o=ABSENT	CERV/IX EXAM (DIL./EFF. STA.) ULTRASOUND LENGTH	BLOOD PRESSURE	WEIGHT	URINE (ALBUMIN/GLUCOSE)	NEXT APPOINTMENT	PROVIDER (INITIALS)	COMMENTS

PROBLEMS _____

COMMENTS _____

ACOG ANTEPARTUM RECORD (FORM C)

Patient Addressograph

LABORATORY AND EDUCATION

INITIAL LABS	DATE	RESULT	REVIEWED
BLOOD TYPE	/ /	A B AB O	
D (Rh) TYPE	/ /		
ANTIBODY SCREEN	/ /		
HCT/HGB	/ /	_____ % _____ g/dL	
PAP TEST	/ /	NORMAL/ABNORMAL/_____	
RUBELLA	/ /		
VDRL	/ /		
URINE CULTURE/SCREEN	/ /		
HBsAg	/ /		
HIV COUNSELING/TESTING*	/ /	POS. NEG. DECLINED	
OPTIONAL LABS	**DATE**	**RESULT**	
HGB ELECTROPHORESIS	/ /	AA AS SS AC SC AF $\uparrow A_2$	
PPD	/ /		
CHLAMYDIA	/ /		
GONORRHEA	/ /		
GENETIC SCREENING TESTS (SEE FORM B)	/ /		
OTHER			
8–18-WEEK LABS (WHEN INDICATED/ ELECTED)	**DATE**	**RESULT**	
ULTRASOUND	/ /		
MSAFP/MULTIPLE MARKERS	/ /		
AMNIO/CVS	/ /		
KARYOTYPE	/ /	46,XX OR 46,XY/OTHER_____	
AMNIOTIC FLUID (AFP)	/ /	NORMAL____ ABNORMAL____	
24–28-WEEK LABS (WHEN INDICATED)	**DATE**	**RESULT**	
HCT/HGB	/ /	_____ % _____ 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)	/ /	SIGNATURE _____	
32–36-WEEK LABS	**DATE**	**RESULT**	
HCT/HGB	/ /	_____ % _____ g/dL	
ULTRASOUND (WHEN INDICATED)	/ /		
VDRL (WHEN INDICATED)	/ /		
GONORRHEA (WHEN INDICATED)	/ /		
CHLAMYDIA (WHEN INDICATED)	/ /		
GROUP B STREP	/ /		

COMMENTS/ADDITIONAL LABS

*Check state requirements before recording results.

PROVIDER SIGNATURE (AS REQUIRED)_____

ACOG ANTEPARTUM RECORD (FORM D)

Patient Addressograph

NAME _____
LAST FIRST MIDDLE

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

	COMPLETED	NEED FOR FURTHER DISCUSSION
FIRST TRIMESTER		
☐ HIV AND OTHER ROUTINE PRENATAL TESTS		
☐ RISK FACTORS IDENTIFIED BY PRENATAL HISTORY		
☐ ANTICIPATED COURSE OF PRENATAL CARE		
☐ NUTRITION AND WEIGHT GAIN COUNSELING		
☐ TOXOPLASMOSIS PRECAUTIONS (CATS/RAW MEAT)		
☐ SEXUAL ACTIVITY		
☐ EXERCISE		
☐ 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 PEDIATRICIAN		
☐ POSTPARTUM FAMILY PLANNING/TUBAL STERILIZATION		
THIRD TRIMESTER		
☐ 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		
☐ NEWBORN CAR SEAT		
☐ FAMILY MEDICAL LEAVE OR DISABILITY FORMS		
REQUESTS		

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

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

ACOG ANTEPARTUM RECORD (FORM E)

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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)	NEXT APPOINTMENT	PROVIDER (INITIALS)	**COMMENTS**

Progress Notes

PROVIDER SIGNATURE (AS REQUIRED) _____

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ACOG ANTEPARTUM RECORD (FORM F)

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)	NEXT APPOINTMENT	PROVIDER (INITIALS)	**COMMENTS**

Progress Notes

PROVIDER SIGNATURE (AS REQUIRED) _____

Patient Addressograph

NAME _____
LAST FIRST MIDDLE

ID # _____

Progress Notes

PROVIDER SIGNATURE (AS REQUIRED) _____

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Patient Addressograph

NAME _____
LAST FIRST MIDDLE

ID # _____

Progress Notes

PROVIDER SIGNATURE (AS REQUIRED) _____