UNIVERSITY MEDICAL CENTER

ANTEPARTUM RECORD
DEPARTMENT OF OB/GYN

Physician _____

Date _____

EMERGENCY CONTACT: _____

Addressograph _____

PATIENT

Name _____ Maiden Name _____

Address _____ City _____ State _____ Zip _____

Phone # (_____) _____ Work # (_____) _____ Cell # (_____)

Birthplace _____ Age _____ DOB _____ Marital Status: ❑ S ❑ M ❑ W ❑ D

SS# _____ Race _____ Religion _____

Father's Name _____ DOB _____ Birthplace _____

MEDICAL

Medical Hx _____

Surgical Hx _____

Medications _____ Allergies _____

Fam/Social Hx _____ Drugs _____ Tobacco _____ Alcohol _____

Cats? ❑ Yes ❑ No Hx Chicken Pox ❑ Yes ❑ No Advance Directive ❑ Yes ❑ No Copy on Chart ❑ Yes ❑ No

Genetic Hx _____

Infertility Hx _____

Gyn Hx _____

OBSTETRICS

Grav _____ Para _____ AB _____ Cat _____ X _____ X _____ LMP _____ EDC _____

Ultrasound: Date Performed _____ CGA _____ wks EDC (US) _____

Previous Pregnancies (Last 7)

Year	Type	GA	WT	Sex	Length of Labor	Complications/Comments

RISK ASSESSMENT EVALUATION

INITIAL ASSESSMENT

PATIENT MAY BE AT RISK FOR

❑ Early Pregnancy Loss
❑ Fetal Genetic Abn
❑ Fetal Structural Abn
❑ Gestational Diabetes
❑ Early Pregnancy Loss
❑ Maternal/Fetal Infection
❑ Isoimmunization
❑ Size-Date Discrepancy
❑ IUGR
❑ Preterm Labor/Delivery
❑ PIH/Preeclampsia
❑ Post-Term Pregnancy
❑ Medical Complications
❑ Surgical Complications
❑ Management Plan Conflict
❑ Emotional Difficulty
❑ Labor/Delivery Difficulty
❑ Parenting Difficulty
❑ Other

❑ **PATIENT NOT AT INCREASED RISK AT INITIAL ASSESSMENT**

Signature _____ M.D.

M.R.# _____

DATE	LABORATORY	RESULTS	DATE	LABORATORY	RESULTS
	Type/Rh			Sickle Cell	
	AB Screen			AFP3	
	Hgb/Hct/WBC/PLT			Amniocentesis	
	Serology			1 Hr. Glucola	
	Rubella			Repeat H/H	
	Varicella			STS (repeat)	
	Hepatitis Bs Ag			Repeat Antibody Screen Rhogam	
	Toxoplasmosis			Beta Strep.	
	Urine C &S				3 HR
	Pap Smear			3 HR GTT	FBS / 1 HR / 2 HR
	HIV Counseling ❑ Yes ❑ No				
	HIV Testing	❑ Refused ❑ Positive ❑ Negative		Other	
	Hgb Electrophoresis			Other	
	G.C.			Other	
	Chlamydia			Other	
	Cystic Fibrosis Testing	❑ Refused ❑ Positive ❑ Negative		Other	

RISK ASSESSMENT UPDATES (as indicated)

Date of Referral	Date Done	Additional Diagnosis/Referral	Initial	Date of Referral	Date Done	Additional Diagnosis/Referral	Initial
		Genetics					
		Peds Cardiology					
		Diabetes Center					

INITIAL PHYSICAL EXAM

Date _____ Ht. _____ Wt. _____ BP _____/_____

HEENT		Genitalia	
Breasts		Cervix	
Lungs		Vagina	
Heart		Uterus	
Abdomen		Adnexa	
Extremities		Rectal	
Neuro		Pelvis	

Signature _____ MD Date _____

ANTEPARTUM VISITS

Name _____ Age _____

E.D.C. by L.M.P. _____

Risk Factors _____

EDC. by U/S _____

PAIN INTENSITY SCALE – 0 - 10

0	1-3	4-7	8-10
None	Mild	Moderate	Severe

Addressograph

Date	Gest. Age / Fundus	Presentation	FHR	B.P.	WT.	ALB / GLUC	PAIN	Notes	Examiner

Signature _____ MD Date _____

ADDITIONAL NOTES

DATE	
	Addressograph