

DATE _____
 NAME _____
 LAST FIRST MIDDLE
 ID # _____ HOSPITAL OF DELIVERY _____
 NEWBORN'S PHYSICIAN _____ REFERRED BY _____

Tennessee Valley OB/Gyn Clinic P.C.
910 Adams Street, Suite 200
Huntsville, Alabama 35801

FINAL EDD _____ PRIMARY PROVIDER/GROUP _____

BIRTH DATE MONTH DAY YEAR	AGE	RACE	MARITAL STATUS S M W D SEP	ADDRESS			
OCCUPATION	EDUCATION (LAST GRADE COMPLETED)			ZIP	PHONE	(H)	(O)
LANGUAGE							
HUSBAND/DOMESTIC PARTNER			PHONE				
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 MF	TYPE DELIVERY	ANES.	PLACE OF DELIVERY	PRETERM LABOR YES/NO	COMMENTS/ COMPLICATIONS

MEDICAL HISTORY

	<input type="radio"/> Neg. + Pos.	DETAIL POSITIVE REMARKS INCLUDE DATE & TREATMENT		<input type="radio"/> Neg. + Pos.	DETAIL POSITIVE REMARKS INCLUDE DATE & TREATMENT
1. DIABETES			17. D (Rh) SENSITIZED		
2. HYPERTENSION			18. PULMONARY (TB, ASTHMA)		
3. HEART DISEASE			19. SEASONAL ALLERGIES		
4. AUTOIMMUNE DISORDER			20. DRUG/LATEX ALLERGIES/ REACTIONS		
5. KIDNEY DISEASE/UTI			21. BREAST		
6. NEUROLOGIC/EPILEPSY			22. GYN SURGERY		
7. PSYCHIATRIC			23. OPERATIONS/ HOSPITALIZATIONS (YEAR & REASON)		
8. DEPRESSION/POSTPARTUM DEPRESSION			24. ANESTHETIC COMPLICATIONS		
9. HEPATITIS/LIVER DISEASE			25. HISTORY OF ABNORMAL PAP		
10. VARICOSITIES/PHLEBITIS			26. UTERINE ANOMALY/DES		
11. THYROID DYSFUNCTION			27. INFERTILITY		
12. TRAUMA/VIOLENCE			28. RELEVANT FAMILY HISTORY		
13. HISTORY OF BLOOD TRANSFUS.			29. OTHER		
	AMT/DAY PREPREG	AMT/DAY PREG	# YEARS USE		
14. TOBACCO					
15. ALCOHOL					
16. ILLICIT/RECREATIONAL DRUGS					

COMMENTS _____

ANTEPARTUM RECORD

SYMPTOMS SINCE LMP

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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			19. ANY OTHER		
11. CYSTIC FIBROSIS					

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			5. OTHER (See Comments)		
3. RASH OR VIRAL ILLNESS SINCE LAST MENSTRUAL PERIOD					

COMMENTS _____

INTERVIEWER'S SIGNATURE _____

INITIAL PHYSICAL EXAMINATION							
DATE _____ / _____ / _____	HEIGHT _____	BP _____					
1. HEENT	<input type="checkbox"/> NORMAL	<input type="checkbox"/> ABNORMAL	12. VULVA	<input type="checkbox"/> NORMAL	<input type="checkbox"/> CONDYLOMA	<input type="checkbox"/> LESIONS	
2. FUNDI	<input type="checkbox"/> NORMAL	<input type="checkbox"/> ABNORMAL	13. VAGINA	<input type="checkbox"/> NORMAL	<input type="checkbox"/> INFLAMMATION	<input type="checkbox"/> DISCHARGE	
3. TEETH	<input type="checkbox"/> NORMAL	<input type="checkbox"/> ABNORMAL	14. CERVIX	<input type="checkbox"/> NORMAL	<input type="checkbox"/> INFLAMMATION	<input type="checkbox"/> LESIONS	
4. THYROID	<input type="checkbox"/> NORMAL	<input type="checkbox"/> ABNORMAL	15. UTERUS SIZE	_____ WEEKS		<input type="checkbox"/> FIBROIDS	
5. BREASTS	<input type="checkbox"/> NORMAL	<input type="checkbox"/> ABNORMAL	16. ADNEXA	<input type="checkbox"/> NORMAL	<input type="checkbox"/> MASS		
6. LUNGS	<input type="checkbox"/> NORMAL	<input type="checkbox"/> ABNORMAL	17. RECTUM	<input type="checkbox"/> NORMAL	<input type="checkbox"/> ABNORMAL		
7. HEART	<input type="checkbox"/> NORMAL	<input type="checkbox"/> ABNORMAL	18. DIAGONAL CONJUGATE	<input type="checkbox"/> REACHED	<input type="checkbox"/> NO	_____ CM	
8. ABDOMEN	<input type="checkbox"/> NORMAL	<input type="checkbox"/> ABNORMAL	19. SPINES	<input type="checkbox"/> AVERAGE	<input type="checkbox"/> PROMINENT	<input type="checkbox"/> BLUNT	
9. EXTREMITIES	<input type="checkbox"/> NORMAL	<input type="checkbox"/> ABNORMAL	20. SACRUM	<input type="checkbox"/> CONCAVE	<input type="checkbox"/> STRAIGHT	<input type="checkbox"/> ANTERIOR	
10. SKIN	<input type="checkbox"/> NORMAL	<input type="checkbox"/> ABNORMAL	21. SUBPUBIC ARCH	<input type="checkbox"/> NORMAL	<input type="checkbox"/> WIDE	<input type="checkbox"/> NARROW	
11. LYMPH NODES	<input type="checkbox"/> NORMAL	<input type="checkbox"/> ABNORMAL	22. GYNECOID PELVIC TYPE	<input type="checkbox"/> YES	<input type="checkbox"/> NO		

COMMENTS (Number and explain abnormal) _____

EXAM BY _____

ANTEPARTUM RECORD

NAME _____
 LAST FIRST MIDDLE

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

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
- OTC Drugs

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

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 ¹ 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	/ /		
AMNIOCVS	/ /		
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	/ /		

ANTEPARTUM RECORD

Provider Signature (as required) _____

