Appendix E – Prenatal Record

Chart No.	Service
Name	Provided at:
D.O.B.	Med. Grp._____ Provider_____

Logo Area

Patient Name	Age/DOB:	Marital Status: M S W D Sep Part
Phone Number H: W:	Emergency Contact: Phone:	
Address:	Patient Occupation:	
Birthplace (City, State, Country)	Interpreter Need? Y N Primary Language:	
Husband/Partner's name	Occupation	
Current Involvement	Phone Number H: W:	
Hospital of Delivery:	Plans for Newborn: keep adopt unsure	
Provider: MD DO CNM	Newborn's Physician:	

Gestational Age Assessment
Menses: Interval: _____ Regularity: _____ LNMP: Certain?
Conception date:
Use of BC: Yes_____ No_____ Type: _____ If OCP – last taken _____
Pregnancy tests: Type: Date: Result:
Quickening date:
Ultrasound: Date: Size: Sonar EDD:
Physical Assessment Factors Considered (circle): Initial uterine size Uterus at umbilicus FHR by doptone FHR by fetoscope
EDD revision based on:

Past Obstetrical History

Total Preg	Full-term	Premature	Ab./Induced		Abortions Spont.		Ectopics	Multiple Births	Living
Date of Del./Ab.	Sex	Name	Wt.	Hrs. in Labor	Type of Delivery	Weeks Gestation	Comments/Complications		

Medical History	Pt (+/-)	Fam (+/-)	Notes	Medical History	Pt (+/-)	Fam (+/-)	Notes
Allergic rhinitis/sinusitis				Malignancy, specify:			
Cardiac murmur				Treatment for substance abuse			
Congenital heart disease, valve(s) affected:				Other:			
Rheumatic heart disease				**Surgical History**			
Needs SBE prophylaxis				ENT, year:			
Hypertension				Cardiac, year:			
Asthma				GI, specify: year:			
Other pulmonary disease				Gynecologic, specify: year:			
Diabetes mellitus				Other:			
Thyroid disease				Other:			
Cystitis				Anesthetic complications			
Pyelonephritis				**Gynecologic History**			
Anemia				Infertility			
Blood transfusion(s)				Clomiphene			
Psych. Disorder, type: year:				Supra ovulation medications			
Thrombophlebitis, deep/DVT year:				In vitro fertilization			
Embolism, year:				Pelvic trauma, year:			
Epilepsy/seizure disorder				PID, year:			
Migraine headache				Uterine anomaly/DES exposure			
Collagen disorder, specify:				Cervical incompetence			
Chronic back pain				Repetitive pregnancy loss			
Ulcer/gastritis				Abnormal Pap smear year:			
Gall bladder disorder				Cervical carcinoma in situ			
Inflammatory bowel disease				Conization/LEEP/cryo year:			
Hepatitis, specify:							

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Laboratory

Initial Labs	Date	Result	Reviewed by
Blood Type		A B AB O	
D (Rh) Type		neg pos	
Antibody Screen		neg pos	
CBC & platelets			
Rubella		immune not immune	
RPR		Non-reactive reactive	
GC/Chlamydia			
Hepatitis BsAg		neg pos	
HIV (with consent)		Non-reactive reactive	
Urine Culture		no growth pos_____	
Pap Smear		normal abnorm____	
Immunizations & Chemoprophylaxis:	**Date**		
•Td Booster IM		Lot #_____ Init._____	
•Influenza IM (must be ≥ 14 weeks EGA)		Lot #_____ Init._____	
16-18 Week Labs (when indicated)	**Date**	**Result**	**Reviewed**
Maternal Serum Screen		normal abnorm____	
Amnio/CVS			
Karyotype Fetal Anomaly Screening			
Amniotic Fluid (AFP)			
RhoGAM IM (for amnio) 22 weeks		Lot #_____ Init._____	
24-28 Week Labs (when indicated)	**Date**	Result	**Reviewed**
Diabetes Screen		1 Hr. _____	
GTT (if screen abnormal)		FBS___ 1 Hr. ___ 2 Hr. ___ 3 Hr. ___	
D (Rh) Antibody Screen		neg pos	
RhoGAM IM		Lot #_____ Init._____	
32-36 Week Labs (when indicated)	**Date**	**Result**	**Reviewed**
		1 Hr. _____	
GTT (if screen abnormal)		FBS___ 1 Hr. ___ 2 Hr. ___ 3 Hr. ___	
Group B Strep **Date**	**Date**	neg pos	
Other Labs	**Date**	**Result**	**Reviewed**

Sono Date	Sono EDD	Comments

Fetal Testing	**Date**									
	NST									
	BPP/AFI									

Education/Counseling

Educational Topics	Date	Init
Visit at 6-8 Weeks		
Lifestyle		
Warning Signs		
Course of Care		
Physiology of Pregnancy		
Nutrition and Supplements		
Referral PTL Education Class		
HIV Counseling		
Risk Profile Form Completion:		
- Risk Assessment (preterm labor)		
- Infectious Disease (ID) screening		
- Genetic Screening		
- Workplace Envir./Lifestyle Screening		
Visit at 10-12 Weeks		
Fetal Growth		
Future Lab Testing		
Breast-Feeding		
Influenza IM for due date 11/1-5/31		
Body Mechanics		
Visit at 16-18 Weeks		
Second Trimester Growth		
Quickening		
Lifestyle		
Physiology of Pregnancy		
Visit at 22 Weeks		
PTL Signs		
Labor Class		
Family Issues		
Length of stay		
Gestational DM		
Rh Status		
Visit at 28 Weeks		
Continuing Work		
Physiology of Pregnancy		
Fetal Growth/Movement		
Screen for Domestic Abuse		
PTL Risk Assessment		
Optional Reassess for ID risk		
Postpartum Depression		
Birth Control Plans		
Visit at 32 Weeks		
Travel		
Sexuality		
Pediatric Care		
Episiotomy		
Labor and Delivery Issues		
Warning Signs/PIH		
Postpartum Care		
Birth Control Plans		
Visit at 36 Weeks		
Attended/Attending Prenatal Classes		
Mgmt. of Late Preg. Signs & Symptoms		
Visits at 38-41 Weeks		
Postpartum Vaccinations		
Infant CPR		
Post-term Mgmt.		
Labor and Delivery Update		

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Substance Use

Substance			Amt/Day PrePreg	Amt/Day Preg	Spouse/ Partner Use
Tobacco	Y	N			
Alcohol	Y	N			
Street Drugs Specify:	Y	N			

Allergies

	NKDA
	Latex allergy, specify reaction:
	Med. allergy: _____ Specify reaction:
	Med. allergy: _____ Specify reaction:
	Med. allergy: _____ Specify reaction:

Medication

Medication (Rx and OTC)	Present Dosage	Date Began	Date Discontinued

For VBAC Only (Init._____) Date _____

	Y	N
Record of previous lower segment incision attached to prenatal chart?		
Record of low segment incision confirmed?		
Patient counseled regarding VBAC risks?		
Patient received written information about VBAC?		
Patient given informed consent for trial of labor after Cesarean section?		

Initial Physical Exam Performed by: _____ (Init.)
Date _____ PrePreg Wt: _____ Ht: _____ BMI: _____ BP: R: _____ or L: _____

	Normal	Abnormal, specify
HEENT		
Thyroid		
Breast		
Lungs		
Heart		
Abdomen		
Extremities		
Skin		

Gyn Exam

	Normal		+		+
Vulva		Condylomata		Lesions	
Vagina		Inflamed		Discharge	
Cervix		Inflamed		Lesions	
Uterus, weeks _____		Myoma(s)			
Adnexa		Mass			
Rectum		Hemorrhoids			

Postpartum Issues

Breastfeeding: Y N Unsure If yes, attending classes? Y N	Circumcision: Y N Unsure Postpartum birth control:	Desires sterilization (tubal): Y N Unsure __ Tubal literature given Risks, failure, and alternatives discussed by:_____(Init.) Date consent signed:

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Prenatal Record

LMP:	EDD:	Revised EDD (see p.4):	ADD:

Hospital_____

Problem List w/Plans

Problems			Date	Plans
1. Preterm Labor Risk	Yes	No		1.
2. Rh Neg	Yes	No		2.
3.				3.
4.				4.
5.				5.
6.				6.
7.				7.
8.				8.
9.				9.
10.				10.

Visit Flow Sheet

Date	Wks	BP	Pre Preg wt. _____		FHR	Fundal Height	FM*	Posi-tion	Cerv Exam	Patient Concerns**	Other**	See PN+	Return Visit	Init
			Wt	Total Gain										

If more visits are necessary, use supplemental flow sheet

*Fetal Movement

**If more space is needed, use progress notes on next page

+Progress Notes

Initial Identification (Providers)

Init	Name	Init	Name
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

Routing Record

Initial chart copied & sent to hospital:
❑ Copy ❑ Fax
Date_____ Init._____
Updated chart sent to hospital:
❑ Copy ❑ Fax
Date_____ Init._____
Updated chart sent to hospital:
❑ Copy ❑ Fax
Date_____ Init.
❑ EMR

Logo Area

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Supplemental Flow Sheet

Date	Wks	BP	Wt.	Total Gain	FHR	Fundal Height	FM*	Posi-tion	Cerv Exam	Patient Concerns**	Other**	See PN+	Return Visit	Init

*Fetal movement **If more space is needed, use progress notes on next page +Progress Notes

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Progress Notes (entries to be dated)

Return to Table of Contents