PREGNANCY FLOWSHEET

LAST:_____ FIRST:_____ MI:____

LMP:_____ EDC:_____

ALLERGIES:

DATE	PROBLEMS/CONDITIONS	PLAN/ACTION
AGE:	G: P:	
	LAST PAP: UPT:	
		Rh: H/H:
HT:		GCT: GTT:
BMI:		GBS: UDS:

DATE	WT	BP	UA	EGA	FH	FHT	FM	PRESENT	EDEMA	COMMENTS/COMPLAINTS/TREATMENT	F/U	MD

Pre-reg: Peds: Tdap: Flu:

RISKS, PROBLEMS, AND PLANS OF THIS PREGNANCY

LAST NAME_____ **FIRST**_____ **MI**_____ **PT#**_____

LMP_____ **EDC**_____
Month Day Year Month Day Year

Normal ____ **Abnormal** ____

INITIAL LABORATORY RESULTS **DATE** _____

BLOOD TYPE / RH: **PATIENT:**_____ **FATHER:**_____

HEMOGLOBIN:_____ **HEMATOCRIT:**_____ **WBC:**_____

URINE: GLUCOSE:_____ **PROTEIN:**_____ **BLOOD:**_____ **CULTURE:**_____

ANTIBODY SCREEN:_____ **SICKLE CELL:**_____

SEROLOGY:_____ **RUBELLA TITER:**_____

PAP TEST:_____ **CERVICAL CULTURE:**_____

TAY SACHS:_____ **GC:**_____

CHLAMYDIA:_____ **ALPHA FETO PROTEIN:**_____

HIV:_____ **HEPATITIS B:**_____

ULTRASOUND: DATE:_____ **RESULTS:**_____

ULTRASOUND: DATE: _____ **RESULTS:**_____

NOTES

GENETIC STUDY

_____**AMNIOCENTESIS** **DATE:**_____ **RESULTS:**_____

_____**CHORIONIC VILLI BIOPSY** **DATE:**_____ **RESULTS:**_____

PREGNANCY HISTORY

LAST CONTRACEPTIVE
Type_____
Date Stopped_____

MENSTRUAL HISTORY
Cycle_____ Days Onset Age_____
Length_____ Days

LMP: MO____ DAY___ YEAR_____
EDC: MO____ DAY____ YEAR____

PARA_____ **GRAV**_____ **AB**_____ **S E**

# PREG	MO / YR	M / F	WT	GEST. WEEKS	HRS LABOR	TYPE OF DELIVERY	DETAILS OF ANY COMPLICATIONS
1							
2							
3							
4							
5							
6							

PLANS TO ATTEND CHILDBIRTH CLASSES **YES**____ **NO**____

POST TERM MANAGEMENT (42 WEEKS)
DELIVERY SCHEDULED YES____ **NO**____
IF NO, TESTS ORDERED:
_____
_____
_____

BIRTHING PLAN:
Baby's Doctor:_____
Hospital:_____
Anesthesia Planned:_____
Sterilization:_____
Breast Or Bottle:_____
Circumcision: **Yes** _____ **No**_____
Additional Requests:

_____ _____
M.D. SIGNATURE AND DATE

GYNECOLOGICAL / OBSTETRICAL HISTORY

LAST NAME_____ **FIRST**_____ **MI**_____ **PT#**_____

PATIENT - PLEASE COMPLETE

Birthplace **Age** **Date of Birth** **Race** **Marital Status**

_____

Your Occupation **Your Education Completed**

_____

Baby's Father's Name **Father's Telephone #** **Father's Age** **Father's Race** **Father's Occupation**

_____

Person to Contact in Emergency **Telephone #** **Alternate Telephone** **Address**

_____

GENERAL HISTORY - SELF / FAMILY

Please check if you or if any of your relatives have had any of the conditions listed below
IF YOU ARE UNSURE OF ANY CONDITION, PLEASE CIRCLE THAT CONDITION

FAMILY No	FAMILY Yes	SELF No	SELF Yes	Condition	FAMILY No	FAMILY Yes	SELF No	SELF Yes	Condition
				Cancer					Infertility
				High Blood Pressure					Blood Clots / Varicose Veins
				Rheumatic Fever					Sexually Transmitted Disease
				Lung Disease					Genital Herpes
				Stomach / Bowel Problems					Condylomata (Warts)
				Kidney Disease					Chlamydia
				Urinary Problems, Infections / Malformations					Infectious Diseases:
				Diabetes Mellitus					Hepatitis
				Anemia / Blood Disorders					Tuberculosis
				Other Endocrine / Hormone Disorders					PKU
				Nervous Mental Disorders					DES Exposure
				Convulsive Disorders - Epilepsy					
				Abnormal Babies					
				Genetic Disease					
				Twins					

Does the baby's father, or his family, have any history of abnormal babies or genetic disease? _____**No** _____**Yes**

HABITS / ENVIRONMENTAL FACTORS

TOBACCO & CAFFEINE

Coffee / Tea_____ cups/day
Cola or other caffeine drinks_____ / day
Cigarettes - Now_____ / day _____ / years
Cigarettes - Ever _____ / day _____ / years
Stopped when? _____

ALCOHOL

_____Drinks per day
_____Drinks per week

MISC

Are you around cats? _____No _____Yes
Do you use a hot tub? _____No _____Yes
Do you have a regular exercise routine? _____No _____Yes
Do you, or have you used drugs (marijuana, cocaine, meth, LSD)? _____No _____Yes

ALLERGIES: _____

PLEASE LIST ALL TIMES YOU HAVE BEEN HOSPITALIZED, OPERATED ON OR SERIOUSLY INJURED

Year	Operation, Illness, Injury	Hospital, City, State

THIS PREGNANCY HISTORY AND PHYSICAL EXAMINATION

LAST NAME_____ FIRST_____ MI____ PT#_____

HISTORY SINCE LAST MENSES

NO	YES	CONDITION
O	O	Headaches
O	O	Abdominal Pain
O	O	Vaginal Discharge
O	O	Vaginal Bleeding
O	O	Edema (Specify Area)

NO	YES	CONDITION
O	O	Febrile Episode
O	O	Rubella (German Measles) Exposure
O	O	Other Vital Exposure
O	O	Radiation Exposure Including Dental X-Rays
		Other_____
		_____
O	O	Cocaine, Marijuana, Alcohol, Or Other Recreational Drugs

MEDICATIONS / DRUGS TAKEN SINCE LAST MENSTRUAL PERIOD

NO	YES	
O	O	Fertility(List)
		_____
O	O	Prescription
		_____
O	O	Non Prescription
		_____

PHYSICAL EXAMINATION

TEMP_____ PULSE_____ RESP_____ / _____ HEIGHT_____ WEIGHT_____

	NORMAL	ABNORMAL
1. HEAD AND NECK		
Ears	O	O
Nose	O	O
Eyes	O	O
Mouth	O	O
Thyroid	O	O
2. THORAX, HEART, LUNGS		
Breast	O	O
Heart	O	O
Rhythm	O	O
Murmurs	O	O
Gallop	O	O
Lungs	O	O
Rales, Rhonchi	O	O
Wheezing	O	O
3. ABDOMEN		
Tenderness	O	O
Masses	O	O
Hernia	O	O
Liver	O	O
Inguinal Nodes	O	O
Surgical Scars	O	O
4. MUSCULOSKELETAL		
Extremities	O	O
Back	O	O
5. SKIN	O	O
6. NEUROLOGICAL	O	O
Deep Tendon Reflexes Grade 1 2 3 4	O	O
7. PELVIC		
External Genitalia	O	O
Vagina	O	O
Cervix	O	O
Uterus (Size / Position)	O	O
Adnexa	O	O
8. RECTAL	O	O
9. BONY PELVIS	O	O

PHYSICIAN NOTES

DIAG CONJ. _____ SHAPE SACRUM_____ SS. NOTCH_____
ISCHIAL SPINES_____ PUBIC ARCH_____ TRANS OUTLET_____
POST SAG. DIAMETER_____ COCCYX_____

PELVIC CLASS
O GYNECOID O ADEQUATE
O ANTHROPOID O BORDERLINE (EST)
O ANDROID O CONTRACTED
O PLATYPELLOID

_____
M.D. SIGNATURE AND DATE