

Appendix E – Prenatal Record

Logo Area

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

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: _____ LNMP: _____	Regularity: _____ 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 doppler 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:			
Other pulmonary disease				year:			
Diabetes mellitus				Gynecologic, specify:			
Thyroid disease				year:			
Cystitis				Other:			
Pyelonephritis				Anesthetic complications			
Anemia				Gynecologic History			
Blood transfusion(s)				Infertility			
Psych. Disorder, type:				Clomiphene			
year:				Supra ovulation medications			
Thrombophlebitis, deep/DVT				In vitro fertilization			
year:				Pelvic trauma, year:			
Embolism, year:				PID, year:			
Epilepsy/seizure disorder				Uterine anomaly/DES exposure			
Migraine headache				Cervical incompetence			
Collagen disorder, specify:				Repetitive pregnancy loss			
Chronic back pain				Abnormal Pap smear			
Ulcer/gastritis				year:			
Gall bladder disorder				Cervical carcinoma in situ			
Inflammatory bowel disease				Conization/LEEP/cryo			
Hepatitis, specify:				year:			

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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	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 Y N Specify:			

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

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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		FHR	Fundal Height	FM*	Position	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

