MEDICAL RECORD - ANTEPARTUM SUMMARY SHEET

For use of this form, see MEDCOM Circular 40-16

This form will be completed by the health care provider

PATIENT'S NAME	AGE	STATUS (AD/FM/DD)	DUTY PROFILE	PRIMARY CARE CLINIC/PROVIDER

ADDRESS OR EMAIL	HOME PHONE	ALTERNATE PHONE	SIGNIFICANT OTHER

GRAVIDA: FULL TERM: PRETERM: AB: LIVING:

PRE PREGNANT HEIGHT: WEIGHT: BMI: IDEAL TERM WT: NUTRITION CONSULT: ☐ Y ☐ N

ALLERGIES: ☐ Y ☐ N SPECIFY: TRANSFUSIONS: ☐ Y ☐ N BREASTFEEDING: ☐ Y ☐ N

CURRENT MEDICATIONS:

TOBACCO: ☐ Y ☐ N AMOUNT: ALCOHOL USE: ☐ Y ☐ N AMOUNT: STREET DRUGS: ☐ Y ☐ N

ETHNICITY OF PATIENT: ETHNICITY OF BABY'S FATHER:

INITIAL EDD: LMP: SURE OF LMP: ☐ Y ☐ N CORRECTED EDD:

DATE																	
WEEKS GESTATION																	
BLOOD PRESSURE																	
WEIGHT																	
PAIN (Scale 0-10)																	
FUNDAL HEIGHT																	
PRESENTATION																	
FETAL HEART RATE																	
√ IF NOTE IS WRITTEN																	
√ IF CPG EDUC DONE																	
PROVIDER INITIALS																	
NEXT APPOINTMENT																	

DATE		DATE	

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*

UNCOMPLICATED PREGNANCY GUIDELINE: ☐ Y ☐ N

DATE OFF GUIDELINE:

REASONS:

PATIENT HISTORY **(Check Yes or No)**

	Y	N		Y	N		Y	N		Y	N		Y	N
(1) DIABETES			(2) HYPERTENSION			(3) HEART DISEASE			(4) AUTOIMMUNE DISORD.			(5) KIDNEY DISEASE		
(6) UTI			(7) PSYCHIATRIC D/O			(8) NEURO/SEIZURE D/O			(9) HEPATITIS			(10) LIVER DISEASE		
(11) VARICOSITIES/PHLEB			(12) THYROID DYSFUNC			(13) RH SENSITIZED			(14) ASTHMA			(15) BREAST PROBLEMS		
(16) ABNORMAL PAP			(17) UTERINE ABNOR			(18) INFERTILITY			(19) SURG HX			(20) RELEVANT FAM HX		
(21) ANESTHESIA COMP			(22) DOMESTIC ABUSE			(23) TB			(24) PULM DISEASE			(25) OTHER		

REMARKS:

PAST PREGNANCIES

DATE	WEEKS GEST	LENGTH LABOR	TYPE DELIVERY	ANES / ANAL	HOSPITAL LOCATION	SEX	WEIGHT	COMPLICATIONS / REMARKS

INFECTION HISTORY (Check Yes or No)	Y	N		Y	N
HIGH RISK FOR HEPATITIS			HX OF STD: GC, CHLAMYDIA, SYPHILIS, HPV		
EXPOSED TO TB			HX OF CHICKEN POX		
PATIENT OR PARTNER WITH HX OF GENITAL HERPES			OTHER INFECTION (SPECIFY):		
RASH OR VIRAL ILLNESS SINCE LMP					

GENETIC RISK SCREENING (Includes patient, baby's father, or anyone in either family.)

	Y	N	REMARKS		Y	N	REMARKS
THALASSEMIA (HIGHER RISK IN PTS WITH ITALIAN/GREEK/ MEDITERRANEAN OR ASIAN BACKGROUND)				RECURRENT PREGNANCY LOSS OR STILLBORN. IF YES, WHAT WORK UP HAS BEEN DONE?			
NEURAL TUBE DEFECT (MENINGOMYELOCELE, SPINA BIFIDA, ANENCEPHALY)				SICKLE CELL DISEASE AND TRAIT (HIGHER RISK IN PTS WITH AFRICAN BACKGROUND)			
TAY-SACHS (HIGHER RISK IN PTS WITH JEWISH, CAJUN, FRENCH CANADIAN BACKGROUND)				MATERNAL METABOLIC DISORDER (e.g., TYPE 1 DM, PKU, ETC.)			
OTHER BIRTH DEFECTS				MUSCULAR DYSTROPHY			
PATIENT'S AGE > 34 AT DELIVERY				MENTAL RETARDATION / AUTISM			
DOWN SYNDROME				CYSTIC FIBROSIS			
CONGENITAL HEART DISORDER				OTHER INHERITED GENETIC OR CHROMOSOMAL DISORDER / RISKS			
HEMOPHILIA							

PHYSICAL EXAMINATION √ Normal or None X Abnormal

(1) GENERAL		(2) HEAD & NECK		(3) EYES		(4) EARS		(5) NOSE	
(6) MOUTH		(7) THROAT		(8) TEETH		(9) CHEST		(10) BREASTS	
(11) NIPPLES		(12) LUNGS		(13) HEART		(14) ABDOMEN		(15) HERNIA	
(16) BACK		(17) EXTREMITIES		(18) NEUROLOGIC		(19) SKIN		(20) LYMPHATIC	

EXT. GENITALIA VAGINA

CERVIX UTERUS

ADNEXA RECTAL

ASSESSMENT / PLAN:

Provider's Signature: _____ **Date:** _____