MEDICAL RECORD – ANTEPARTUM SUMMARY SHEET

Name:	Age:	Partner's Name:	Patients SSN last 4#:
			Enrolled in Relay Health:

ADDRESS:	Primary contact number:
CITY:	Emergency contact number:

Patient Ethnicity:	Unit and Command contact:	
Father of baby Ethnicity:	Primary Language(s):	Plan to Breastfeed: Y N U
Height: PrePregnancy Weight: BMI:	Alcohol Use: Y N	Amount:
Med Allergies: Y N List:	Tobacco Use: Y N	Amount:
Latex Allergy: Y N	Street Drug: Y N	Amount:

Total Preg:	Full Term:	Preterm:	AB, Spontaneous:	AB, Elective:	Ectopic:	Living:
Initial EDD:	LMP:	Sure of LMP: Y N	Corrected EDD:			

DATE														
WEEKS GESTATION														
BLOOD PRESSURE														
PULSE														
WEIGHT														
PAIN														
FUNDAL HEIGHT														
PRESENTATION														
FHR														
FETAL MOVEMENT														
CERVIX EXAM														
LABS ORDERED														
PROVIDER INITIALS														
RETURN TO CARE														

DATE:	**NOB LABS/ Baseline:**	**DATE:**	**15-20 weeks**
	WBC HGB HCT PLT		CYSTIC FIBROSIS: NEG POS Declined
	HEPATITIS B RPR		MSAFP: NEG POS Declined
	BLOOD TYPE/Rh ABS		**28 weeks**
	Rubella: VARICELLA		WBC HGB HCT PLT
	UA/CULTURE		1 HR Glucose
	HIV Hgb Electrophoresis		3 HR Glucose: F 1HR 2HR 3HR
	CYTOLOGY		**36 weeks** GBS:
	GC CHLAMYDIA HSV Hx:		
	Early Glucola TSH		
	24 HR protein OB Panel AST ALT CRT		

ULTRASOUNDS

Date	EGA by Date	EGA by U/S	EDD	Comments

Patient Identification: Name (last, first)

EFMP:

Learning:

Pregnancy History please list all pregnancies (including stillbirths, abortions, miscarriages, and ectopic pregnancies)

DATE Month/Yr	Weeks Gest	Length of Labor	Type of Delivery	Anes; IV Meds/ Epidural	Place of Delivery	Sex (M,F)	Birth Weight	Complications

1. Is this a planned pregnancy? Yes ☐ No ☐ Is this a desired pregnancy? Yes ☐ No ☐

2. How many preterm deliveries have you had (born more than 3 weeks before the baby's due date)?

3. How many live births have you had? How many living children do you have?

4. How many of the following have you experienced? Stillbirth Abortion Miscarriage Ectopic

Menstrual History

Are your periods usually regular? Yes ☐ No ☐

Age period started How long is your cycle (beginning of one to beginning of next) for example 28 days.

What type of birth control, if any, did you last use? When?

Patients Medical History

	- Neg +Pos	Detail Positive Remarks Include Date and Treatment		- Neg +Pos	Detail Positive Remarks Include Date and Treatment
1. Diabetes			15. Pulmonary (TB/ Asthma)		
2. Hypertension (high blood pressure)			16. Seasonal Allergies		
3. Heart Disease			17. Breast (Lumps, Biopsys etc.)		
4. Autoimmune disorder			18. GYN Surgery		
5. Kidney disease/ UTI			19. Surgeries/ Hospitalizations (year/reason)		
6. Neurological disorder / Epilepsy			20. Anesthetic Complications		
7. Depression/ Post-Partum			21. D (Rh) Sensitized		
8. Psychiatric Disorders (Anxiety/ Bi-Polar, Etc).			22. History of abnormal pap		
9. Hepatitis/Liver Disease			23. Uterine Abnormalities		
10. Varicose Veins/Phlebitis			24. Infertility		
11. Blood clots			25. Ulcer/Stomach Problems		
12. Thyroid dysfunction			26. History of blood transfusion		
13. Trauma/Violence			27. Other Medical Conditions not listed		

14. Anyone in your family *(Parents/Siblings)* diagnosed with Hypertension (high blood pressure) or Diabetes prior to the age of 50? ☐ Yes ☐ No

If yes, please list the condition and person:

Patient's Signature

Interviewer's Signature

SCREENING QUESTIONNAIRE

Genetic Screening (Includes Patient, Baby's Father, or anyone in either family)

	Yes	No		Yes	No
1. Patient's age 35 years or older at due date			11. Huntington's Chorea		
2. Muscular Dystrophy			12. Mental Retardation/ Autism		
3. Tay-Sachs (Ashkenazi Jewish, Cajun, French, Canadian)			If yes, was person tested for Fragile X		
4. Congenital Heart defect			13. Other inherited genetic or chromosomal disorder		
5. Down Syndrome			14. Lupus or autoimmune disorders		
6. Neural tube Defect (Menigomyelocele, Spina Bifida, or anencephaly)			15. Metabolic disorders (Type 1 Diabetes, PKU)		
7. Sickle Cell disease or trait			16. Multiple births (twins, triplets, ect.)		
8. Hemophilia or other blood disorders			17. Recurrent pregnancy loss or stillbirth (two or more losses)		
9. Thalassemia (Italian, Greek, Mediterranean, or Asian background)			18. Patient or baby's father with birth defects not listed above		
10. Cystic Fibrosis			Example: clubbed feet		

Please list any "YES" responses, including relationship:

Infection History	**Yes**	**No**	**Unk**
1. Do you have a history of pelvic infection requiring hospitalization or surgery?			
2. Do you currently have or have your ever been exposed to or lived with someone with tuberculosis?			
3.Have you ever had a MRSA infection? If yes When?			
4. Do you currently have or have you ever been diagnosed or been exposed to any sexually transmitted diseases including Chlamydia, Herpes, Gonorrhea, Syphilis, Genital Warts, HPV, or HIV?			
If yes which one and when?			
5. Do you currently have or have you ever had a kidney or bladder problems, frequent UTI or cystitis?			
6. Do you live in a house with cats? If yes, Who takes care of the cat litter?			
7. Have you previously had chickenpox?			
If no have you been vaccinated against chickenpox?			
8. Have you had a rash or viral illness since your last menstrual period?			
9. Have you traveled outside of the United States since becoming pregnant? If yes, Where?			
10. Have you been stationed overseas? If yes, where?			
11. Were you born outside the United States? If yes, where?			

Domestic Abuse	**Yes**	**No**
13. Do you feel safe where you live?		
14. Within the last year have you been forced to participate in sexual activity or engage in sex that makes you feel uncomfortable?		
15. Do you live with anyone who hits you or hurts you in anyway?		
16. Within the last year have you been hit, slapped, kicked, or otherwise physically hurt by someone?		
17. Are you currently or have you ever been abused emotionally or financially?		
18. Has your partner ever prevented you or your family members from meeting your basic needs to include financial and/or physical needs?		
19. Do you have any thoughts or plans of killings yourself or of harming someone else?		

Please explain any "YES" responses not already clarified:

SCREENING QUESTIONNAIRE

Immediate Concerns or questions not stated else where in paperwork?		

Symptoms Assessment

Are you frequently bothered by any of the following?

	Yes	No	Comments		Yes	NO	Comments
Nausea				Blood in Urine			
Vomiting				Feeling tired/poorly			
Heartburn				Fever			
Constipation				Chills			
Diarrhea				Headache			
Abdominal Pain				Vision Changes			
Burning or stinging with urination				Back pain			

If over 16 weeks, are you experiencing any quickening or fetal movement? Yes No

If over 20 weeks, have you or are you experiencing any labor pains or contractions? Yes No
If yes, Please explain? (frequency, duration, pain)

Any other concerns:

Social & Lifestyle	**Yes**	**No**	**N/A**
1. Do you ever drive or ride in a car without wearing a seatbelt?			
2. Have you used tobacco in the last year? (if no skip to question #3)			
a. Have you quit? If yes when?			
b. Do you want to quit?			
c. Would you like to be offered tobacco cessation materials?			
3. Do you drink alcohol? How much? How often? Type? Last used?			
4. Have you ever used street drugs such as marijuana, LSD, Speed, Heroin, Crystal, Crack, Cocaine, Meht, Ectasy, ect.? If yes, Type? How often? Last used?			
5. Since becoming pregnant have you been exposed to x-rays or toxic chemicals?			
6. Do you get regular purposeful exercise (walking for 30+ minutes, weight training, etc.)?			

7. List all prescription medications you have taken since becoming pregnant. **Circle the ones you are currently taking**

8. List all the over-the-counter and herbal medications you have taken since becoming pregnant? (example: Tylenol, Tums, Prenatal Vitamins)

9. What is the highest level of education you have completed?

10. What is your occupation?

11. Do you have a religious preference? If so what demoniation? (optional)

12. Do you have a Durable Power of Attorney or Living will for medical care? ☐ Yes ☐ No If yes please provide a copy to be place in your medical record.

13. Are you enrolled in the Exceptional Family Member Program (EFMP)? ☐ Yes ☐ No

14. What is your best method of learning? (check all that apply) ☐ Reading material ☐ Group Instruction ☐ Pictures ☐ Video Presentation ☐ Demonstration ☐ Individual Instruction ☐ Listening ☐ Other (please specify)

Please explain an "YES" response not already clarified

MEDICAL RECORD- PRENATAL NUTRITION ASSESSMENT

	Yes	No
Do you have any children less than 12 months old?		
Are you currently breastfeeding?		
Do you have food allergies or intolerances?		
Are you a vegetarian?		
Are you having any unusual cravings for non-food items (chalk, dirt, or soap)?		

How would you describe your eating habits, typically when not pregnant? Very Good Good Poor

Are you receiving any food assistance now? (Check all that apply)

Donated Food/commodities School Breakfast School Lunch WIC

Food Stamps Food Pantry Soup Kitchen Food Bank Other (please specify)

Nutrition Survey Please mark yes if statement applies to your typical eating habits ***prior*** to pregnancy.	Yes	Points
1. I eat less than 2 meals per day.	☐	3
2. I eat fewer than 4 servings of fruit and vegetables a day.	☐	2
3. I eat less than 4 servings of milk, yogurt, cheese or other high calcium foods a day.	☐	2
4. I eat more than 3 servings of candy, chips, doughnuts, or other snack foods a day.	☐	2
5. I drink more than 3 (6 ounce) glasses of soft drinks, Kool-Aid, or juice a day.	☐	2
6. I have gained more than 1 pound per week since I became pregnant.	☐	2
7. I have been feeling sick since I found out I'm pregnant and have lost weight.	☐	2
8. My last pregnancy was less than 2 years ago.	☐	2
9. I have diabetes or had gestational diabetes during a past pregnancy.	☐	3
10. I have or had in the past an eating disorder (anorexia, bulimia, other).		Yes
11. I don't always have enough money to buy the food I need.		Yes
12. I take herbal/nutrition supplements, vitamins, energy drinks (other than prenatal vitamins, folate, iron, or calcium) If yes, please list:		
Total:		
Provider/Nurse will fill out information below		

Score

_____0-4 Patient at no/low nutrition risk.

_____5 or more Refer to Prenatal Nutrition Class. Patient at moderate/high nutrition risk.

_____If YES for number 9 or 10, refer to Nutrition Clinic for Individual Consultation.

Patient at moderate/high nutrition risk.

_____If YES for number 11, refer patient to WIC Program

BMI over 35 or under 17, referral to be offered.

Nutrition Consult Indicated: Yes No Consult accepted: Yes No

MEDICAL RECORD- PRENATAL SOCIAL NEEDS

Prenatal Social Needs Assessment

1. Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated
2. I live with my: ☐ Spouse ☐ Parents ☐ Roommate ☐ By myself
3. Will your partner be deployed during your pregnancy? ☐ Yes ☐ No ☐ N/A
   If yes, when? _____ Scheduled to Return? _____
4. Will you be moving from this area during your pregnancy? ☐ Yes ☐ No ☐ N/A
   If yes when? _____ Where? _____
5. I live in: ☐ Post Housing ☐ Barracks ☐ House ☐ Apartment ☐ Mobile Home ☐ Other
6. I am happy with my living accommodations: ☐ Yes ☐ No
7. I have supportive family/friends in this local area: ☐ Yes ☐ No
8. I moved to the area (month/year) _____
9. My partners response to this pregnancy is: ☐ Very Supportive ☐ Somewhat Supportive ☐ Not Supportive ☐ N/A
10. My primary means of transportation is: ☐ Own Car ☐ Partner's Car ☐ Friend's Car ☐ Public Transportation
    ☐ I do not drive/need local resources for medical transport.
11. My current financial status is: ☐ Good ☐ Fair ☐ Poor
12. If this pregnancy was unplanned, which of the following have you considered?
    ☐ Keeping the child ☐ Adoption ☐ Abortion ☐ Foster Placement ☐ Undecided ☐ N/A
13. How many children live with you primarily? _____ Children's Ages: _____
14. What is your biggest concern right now? _____
15. How are you adjusting/dealing with this concern? _____

Patient Identification Sticker: