PREGNANCY FLOW SHEET

LAST NAME: ______________________ **FIRST** ______________________ **MI** ____ **PT#** ____

LMP: ______________________
Month Day Year

EDC: ______________________
Month Day Year

ALLERGIES ____

PROBLEMS AND COMPLICATIONS

DATE	PROBLEM / CONDITION	PLAN / ACTION

FLOW CHART

DATE	WT	BP	UA	EGA	FH	FHT	FM	PRES - ENT	EDE- MA	COMMENTS / COMPLAINTS / TREATMENT	F/U	MD

RISKS, PROBLEMS AND PLANS OF THIS PREGNANCY

LAST NAME:__________ FIRST__________ MI_____ PT#_____

LMP: __________
Month Day Year

EDC: __________
Month Day Year

Normal ☐ Abnormal ☐

INITIAL LABORATORY RESULTS

DATE __________

NOTES

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:__________

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	DETAIL OF ANY COMPLICATIONS
1							
2							
3							
4							
5							
6							

PLANS TO ATTEND CHILDBIRTH CLASSES YES_____ NO_____

BIRTHING PLAN:

Babys Doctor:__________

Hospital__________

Anesthesia Planned__________

Sterilization__________

Breast or Bottle__________

Circumcision: YES_____ NO_____

Additional Request:

____

POST TERM MANAGEMENT (42 Weeks)

DELIVERY SCHEDULED____YES____NO

IF NO, TEST ORDERED:

____

____

____

____

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
				Cancer
				High Blood Pressure
				Rheumatic Fever
				Lung Disease
				Stomach / Bowel Problems
				Kidney Disease
				Urinary Problems, Infections / Malformations
				Diabetes Mellitus
				Anemia / Blood Disorders
				Other Endocrine / Hormone Disorders
				Nervous Mental Disorders
				Convulsive Disorders – Epilepsy
				Abnormal Babies
				Genetic Disease
				Twins

FAMILY No	FAMILY Yes	SELF No	SELF Yes	Condition
				Infertility
				Blood Clots / Varicose Veins
				Sexually Transmitted Disease
				Genital Herpes
				Condylomata (Warts)
				Chlamydia
				Infectious Diseases:
				Hepatitis
				Tuberculosis
				PKU
				DES Exposure

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

HABITS / ENVIRONMENTAL FACTORS

TOBACCO & CAFFEINE

No	Yes	
		Coffee / Tea__________cups / day
		Cola or other caffeine drinks________/ day
		Cigarettes – Now______/ day_______/ years
		Cigarettes – Ever______/ day_______/ years
		Stopped When? ____________

ALCOHOL

Alcohol

________Drinks per day

________Drinks per week

MISC

	No	Yes	
Are you around cats?			
Do you use a hot tub?			
Do you have a regular exercise routine?			
Do you, or have you, used Drugs (marijuana, cocaine, Meth, LSD)?			

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 Include 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	O	O
Grade 1 2 3 4		
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 ANTHROPOID
- O ANDROID
- O PLATYPELLOID

- O ADEQUATE
- O BORDERLINE (EST)
- O CONTRACTED

____

M.D. SIGNATURE AND DATE

TELEPHONE CALLS

LAST NAME:________________________ FIRST ________________________ MI_____ PT#_____

DATE	PERSON	QUESTION	ADVICE