NAME	NOTES

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PRENATAL FLOW RECORD

Date ______________________________

Contact @ Home ____________________

Name ____ Birth Date ________________ Age ____________________

Address ____ Phone ______________________ Bus. Phone ______________

Patient's Business Address ____ Occupation ____________________

Husband's Name __________________________ Bus. Address ____________________ Occupation ____________________

Gynecologic History: Last Pap ________________________________ Number of Pregnancies ____________

Number of Live Births ______________ Miscarriages or Abortions ______________ First Day of Last Menstrual Period ____________ First Day of Previous Menstrual Period ______________

Age of First Menstrual Cycle ______________ How Often ____________________ Length of Cycle ______________________________ Cramps Y ☐ N ☐

Contraceptive History ____

Medical History:

_____DES Exposure
_____Genital Herpes
_____Pelvic Inflammatory
_____Disease
_____Chicken Pox
_____German Measles
_____Measles
_____Diabetes
_____Asthma
_____Smoker
_____Rheumatic Fever
_____Thyroid Disease
_____Hepatitis
_____Seizures
_____High Blood Pressure
_____Thrombophlebitis
_____Urinary Infections
_____Blood Transfusions
_____Heart Disease
_____Migraines
_____Cancer

Habits / Addictions
_____Coffee
_____Alcohol
_____Drugs

Operations: ____

Medication Allergies: ____

Current Medications: ____

Family History: Immediate family ____ Nationality ________________________

Diabetes ____________________________ Cancer ___________________________ Heart Disease ________________________

Twins ____ Hereditary Disorders/Congenital Anomalies ____________________________

Husband:Age ________________ Height ________________ Weight ______________ Blood Type & Rh ________________________

Previous Pregnancies

Name	Date	Weeks	Sex	Birth Weight	Complications of Pregnancy	Length of Labor	Complications of Labor	Anesthesia	Baby Diet	Post-Partum Complications

Abortions

Date	Weeks	Spontaneous or Induced	Operation	Complications

Physical Examination

Height ____________ Usual Weight ____________________________ Thyroid ________________________ Lungs ______________

Back ____________________________ Breasts ____________________________ Nipples ____________________________________

Heart ____

Abdomen ____

Pelvic: Cervix ____________________________________ Uterine Size ______________________________ Adnexae ____________________

Pelvimetry: Shape ____ Adequacy ____

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RISK FACTORS & PROBLEM LIST

1. ______________ • ______________
2. ______________ • ______________
3. ______________ • ______________
4. ______________ • ______________

Age ______________________________

G______ P______ SAB______ Tab______ SB______ LC______

Allergies ______________________________

Breast Feeding________ YES________ NO

LMP ______________________________

EDC by LMP______________ EDC by First Exam__________

EDC by Ultrasound__________ Composite EDC__________

Prenatal Classes__________ Instructor__________

Pediatrician______________________________

Spouse has met Doctor______________________

Referring Doctor__________________________

Insurance ______________________________

____

LAB RESULTS

Hg/Hct Date				Rh Titer Date			

Blood Type and Rh __________ Rhogam__________ VDRL__________

PAP________________ Rubella ________________

O'Sullivan________________________ GTT__________

HIV______________ Hep C Ab ________________

Herpes__________ Urine Culture ________________

Hep B__________ GBS________________________

Cx Cultures ______________________________

AFP Protocol:

Book Given ______________________________

Decision Made ______________________________

Blood Drawn ______________________________

Results ______________________________

Amniocentesis________ Date__________ Results__________

Refused ☐ Date______________ Initial ____________

Visit Date																		
Weeks gestation by dates																		
FETUS	Fundal Height																	
	Heart Rate																	
	Movement																	
	Est. Presentation																	
WT	Pre-Gravid	This Visit																
		Cumulative																
Blood Pressure																		
URINE	Sugar																	
	Albumin																	
Edema																		
SYMPTOMS	Bleeding																	
	Discharge/Itching																	
	Dizziness/Fainting																	
	Headache/Blurred Vision																	
	Leg Cramps																	
	Nausea/Vomiting																	
OPTIONAL	Non Stress Test																	
	Cervical Exam																	
Pregnancy Risk Level																		
Next Appointment																		
Initials																		

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PREGNANCY RISK INDICATORS

	YES	NO
DRUG DEPENDENCIES		
HABITUAL SMOKER (MORE THAN 1 PACK PER DAY)		
PREGNANCY WITHOUT FAMILY OR PARTNERS SUPPORT		
PRIOR TRANSFUSIONS		
INCOMPETENT CERVIX		
HABITUAL ABORTION		
UTERINE SURGERY (NONCESAREAN)		
PRIMIGRAVIDA (IF “YES” SKIP TO “DIABETES”)		
CESAREAN SECTION		
FETAL DEATHS		
NEONATAL DEATHS		
PREMATURE OR LBW INFANTS		
CONGENITAL OR CHROMOSOMAL ANOMALIES		
H.B.W. INFANTS (MORE THAN 10 POUNDS)		
DIABETES		
HEART DISEASE		
GENITAL HERPES		

GENETICS SCREENING

INCLUDES PATIENT, BABY’S FATHER, OR ANYONE IN EITHER FAMILY WITH:

	YES	NO
1. PATIENT’S AGE $>$ 35 YEARS		
2. THALASSEMIA (ITALIAN, GREEK, MEDITERRANEAN, OR ORIENTAL BACKGROUND): MCV $<$ 80		
3. NEURAL TUBE DEFECT (MENINGOMYELOCELE, OPEN SPINE, OR ANENCEPHALY)		
4. DOWN SYNDROME		
5. TAYU-SACHS (EG, JEWISH BACKGROUND)		
6. SICKLE CELL DISEASE OR TRAIT		
7. HEMOPHILIA		
8. MUSCULAR DYSTROPHY		
9. CYSTIC FIBROSIS		
10. HUNTINGTON CHOREA		
11. MENTAL RETARDATION		
IF YES, WAS PERSON TESTED FOR FRAGILE X?		
12. OTHER INHERITED GENETIC OR CHROMOSOMAL DISORDER		
13. PATIENT OR BABY’S FATHER HAD A CHILD WITH BIRTH DEFECTS NOT LISTED ABOVE		
14. $\geq$ 3 FIRST-TRIMESTER SPONTANEOUS ABORTIONS, OR A STILLBIRTH		
15. MEDICATIONS OR STREET DRUGS SINCE LAST MENSTRUAL PERIOD		
IF YES, AGENT(S)		
16. OTHER SIGNIFICANT FAMILY HISTORY (SEE COMMENTS)		

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