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| NAME _   | LAST                         |             |                  |            | FIRST                       |        |         |                    |                            | MIDDLE                     |             |                  |   |         |
|  |                              |             |                  |            | PITAL OF DELIVERY           |        |         |                    |                            |                            |             |                  |   |         |
| ID# _  |                              |             | HOS              | SPITA      | L OF DEL                    | IVERY  |         |                    |                            |                            |             |                  |   |         |
| NEWBOF   | RN'S PHY                     | SICIAN _    |                  |            |                             | REFER  | REE     | ) BY               |                            |                            |             |                  |   |         |
|  |                              |             |                  |            | ,                           | PRIMA  | RY I    | PROVIDER           | GROUF                      |                            |             |                  |   |         |
| FINAL E  | EDD                          |             |                  |            |                             |        |         | A[                 | DRESS                      | i                          |             |                  |   |         |
| BIRTH  | DATE AGE RACE MARITAL STATUS |             |                  |            | ADDRE                       | SS     |         |                    |                            |                            |             |                  |   |         |
| MONTH DAY YEAR S M W D SEP   |                              |             |                  |            |                             |        |         |                    |                            |                            |             |                  |   |         |
| OCCUPATION EDUCATION (LAST GRADE COMPLETED)  |                              |             |                  |            | ZIP                         |        | PHONE   |                    | (H)                        | (0)                        |             |                  |   |         |
| LANGUA   |                              |             |                  | E          | ETHNICITY                   |        |         |                    | INSUR                      | ANCE CARRIE                | ER/MEDICAI  | #                |   |         |
| HUSBAND/DOMESTIC PARTNER PHONE   |                              |             |                  |            | POLIC <sup>1</sup>          |        |         |                    |                            |                            |             |                  |   |         |
| FATHER C   | OF BABY                      |             |                  |            |                             | PHONE  |         |                    | EMER                       | SENCY CONT                 | ACT         |                  | PHONE                                   |         |
| TOTAL PR   | REG                          | FULL TER    | M                | PREN       | MATURE                      | Α      | B, IN   | DUCED              | AB, SF                     | ONTANEOUS                  | E.          | CTOPICS          | MULTIPLE BIRTHS                         | LIVING  |
|  |                              |             | '                |            |                             |        | N       | //ENSTRU           | L HIST                     | ORY                        |             |                  | 7                                       |         |
|  |                              |             | MATE (MON        |            |                             |        |         | LY   YES [         |                            |                            |             |                  | NARCHE                                  |         |
|  | DINKINOWIN<br>FINAL          | □ NOKIW     | AL AMOUNT/       | DUKAI      | ION PRI                     | JK MEN | SES_    | DATE               |                            | JN BCP AT C                | ONCEPI L    | I VES   NIO      | hCG +                                   | <i></i> |
|  |                              |             |                  |            |                             | P/     | AST     | PREGNAN            | ICIES (I                   | AST SIX)                   |             |                  |   |         |
| DATE   |                              | LENGTH      | DI DITI          | OEV        | 77/75                       |        |         |                    |                            | PRETERM                    |             |                  | 0.00445517724                           |         |
| MONTH/<br>YEAR   | GA<br>WEEKS                  | OF<br>LABOR | BIRTH<br>WEIGHT  | SEX<br>M/F | TYPE<br>DELIVERY            | ANE    | S.      | PLACE C<br>DELIVER |                            | LABOR<br>YES/NO            |             |                  | COMMENTS/<br>COMPLICATIONS              |         |
|  |                              |             |                  |            |                             | 4      | $\perp$ |                    |                            |                            |             |                  |   |         |
|  |                              |             |                  |            |                             |        |         |                    |                            |                            |             |                  |   |         |
|  |                              |             |                  |            |                             |        | \       |                    |                            |                            |             |                  |   |         |
|  |                              |             |                  |            |                             |        |         |                    |                            |                            |             |                  |   |         |
|  |                              |             |                  |            |                             |        |         |                    |                            |                            |             |                  |   |         |
|  |                              |             |                  |            |                             |        |         |                    |                            |                            |             |                  |   |         |
|  |                              |             |                  |            |                             |        |         | MEDICAL            | HISTO                      | RY                         |             |                  |   |         |
|  |                              |             | O Neg.<br>+ Pos. |            | AIL POSITIVE<br>LUDE DATE ( |        |         |                    |                            |                            |             | O Neg.<br>+ Pos. | DETAIL POSITIVE RE<br>INCLUDE DATE & TR |         |
| 1. DIABE   | TES                          |             |                  |            |                             |        |         |                    | 17. D (                    | Rh) SENSITIZ               | ED          |                  |   |         |
| 2. HYPER   | RTENSION                     | 1           |                  |            |                             |        |         |                    | 18. PU                     | LMONARY (TE                | B, ASTHMA)  |                  |   |         |
| 3. HEART   | TDISEASE                     |             |                  |            |                             |        |         |                    | 19. SE                     | SONAL ALLE                 | ERGIES      |                  | 1                                       |         |
| 4. AUTOI   | IMMUNE DIS                   | ORDER       |                  |            |                             |        |         |                    |                            | UG/LATEX AL                | LERGIES/    |                  |   |         |
| 5. KIDNE   | Y DISEASE/I                  | ITU         |                  |            |                             |        |         |                    |                            |                            |             |                  |   |         |
| DESCRIPTION OF THE PROPERTY OF | OLOGIC/EPII                  | LEPSY       |                  |            |                             |        |         |                    | 21. BR                     | EAST                       |             |                  |   |         |
| 7. PSYCH   | 25                           |             |                  | 4          |                             |        |         |                    | 22. GY                     | N SURGERY                  |             |                  |   |         |
|  | ESSION/POS<br>ESSION         | TPARTUM     |                  |            |                             |        |         |                    |                            | ERATIONS/                  | SNC         |                  | 1                                       |         |
| 9. HEPAT   | TTIS/LIVER D                 | DISEASE     |                  |            |                             |        |         |                    | 5000                       | SPITALIZATIO<br>AR & REASO |             |                  |   |         |
| 10. VARIC  | OSITIES/PHL                  | EBITIS      |                  |            |                             |        |         |                    | 04. AN                     | COTUETIO OC                | NADI IOATIO | .10              | -                                       |         |
| 11. THYRO  | OID DYSFUN                   | ICTION      |                  |            |                             |        |         |                    | 2000 DOSS                  | ESTHETIC CO                |             | 380              | +                                       |         |
| 12. TRAUN  | MANIOLENC                    | E           |                  |            |                             |        |         |                    |                            | ERINE ANOM                 |             |                  | +                                       |         |
| 13. HISTO  | RY OF BLOO                   | DD TRANSFL  |                  | 100        | Aberle                      | \A\V   |         | VENDO              | SARAGONAMAN<br>SARAGONAMAN | ERTILITY                   |             |                  | 1                                       |         |
|  |                              |             | AMT/[            |            | AMT/E                       |        | 1       | YEARS<br>USE       |                            | T TREATMENT                | <u> </u>    |                  | -                                       |         |
| 14. TOBA   |                              |             |                  |            |                             |        |         |                    |                            | EVANT FAMI                 |             |                  | 1                                       |         |
| 15. ALCOI  |                              | ==          |                  |            |                             |        |         |                    |                            |                            |             |                  | -                                       |         |
| 16. ILLICI   | I/RECREATIO                  | ONAL DRUG   | >                |            |                             |        |         |                    | 30. OT                     | HER                        |             |                  |   |         |
| COMME  | NTS                          |             |                  |            |                             |        |         |                    |                            |                            |             |                  |   |         |

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ACOG ANTEPARTUM RECORD (FORM B)

| SYMPTOMS SINCE LMP |                    |
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|                    |                    |
|                    | SYMPTOMS SINCE LMP |

| GENETIC SCREENING/TERATOLOGY COUNSELING INCLUDES PATIENT, BABY'S FATHER, OR ANYONE IN EITHER FAMILY WITH: |     |    |  |     |    |  |  |  |
|---|-----|----|--|-----|----|--|--|--|
|   | YES | NO |  | YES | NO |  |  |  |
| PATIENT'S AGE 35 YEARS OR OLDER AS OF ESTIMATED DATE OF<br>DELIVERY                                       |     |    | 13. HUNTINGTON'S CHOREA  |     |    |  |  |  |
| 2. THALASSEMIA (ITALIAN, GREEK, MEDITERRANEAN, OR   |     |    | 14. MENTAL RETARDATION/AUTISM  |     |    |  |  |  |
| 2. THALASSEMIA (HALIAN, GREEK, MIEDTERRANDAN, OR<br>ASIAN BACKGROUND): MCV LESS THAN 80                   |     |    | IF YES, WAS PERSON TESTED FOR FRAGILE X?   |     |    |  |  |  |
| NEURAL TUBE DEFECT     (MENINGOMYELOCELE, SPINA BIFIDA, OR ANENCEPHALY)                                   |     |    | 15. OTHER INHERITED GENETIC OR CHROMOSOMAL DISORDER  |     |    |  |  |  |
|   |     |    | 16. MATERNAL METABOLIC DISORDER (EG, TYPE 1 DIABETES, PKU)   |     |    |  |  |  |
| 4. CONGENITAL HEART DEFECT  |     |    | 17. PATIENT OR BABY'S FATHER HAD A CHILD WITH BIRTH DEFECTS  |     |    |  |  |  |
| 5. DOWN SYNDROME  |     |    | NOT LISTED ABOVE   |     |    |  |  |  |
| 6. TAY-SACHS (ASHKENAZI JEWISH, CAJUN, FRENCH CANADIAN)   |     |    | 18. RECURRENT PREGNANCY LOSS, OR A STILLBIRTH  |     |    |  |  |  |
| 7. CANAVAN DISEASE (ASHKENAZI JEWISH)   |     |    | 19. MEDICATIONS (INCLUDING SUPPLEMENTS, VITAMINS, HERBS OR OTC DRUGS)/ILLICIT/RECREATIONAL DRUGS/ALCOHOL SINCE |     |    |  |  |  |
| 8. FAMILIAL DYSAUTONOMIA (ASHKENAZI JEWISH)   |     |    | LAST MENSTRUAL PERIOD  |     |    |  |  |  |
| 9. SICKLE CELL DISEASE OR TRAIT (AFRICAN)   |     |    | IF YES, AGENT(S) AND STRENGTH/DOSAGE   |     |    |  |  |  |
| 10. HEMOPHILIA OR OTHER BLOOD DISORDERS   |     |    | M. ANN OTHER   |     |    |  |  |  |
| 11. MUSCULAR DYSTROPHY  |     |    | 20. ANY OTHER  |     |    |  |  |  |
| 12. CYSTIC FIBROSIS   |     |    |  |     |    |  |  |  |

### COMMENTS/COUNSELING \_

| INFECTION HISTORY                                    | YES | NO | ~  |
|--|-----|----|--|
| LIVE WITH SOMEONE WITH TB OR EXPOSED TO TB           |     |    | 4. HEPATITIS B, C YES□ NO□   |
| 2. PATIENT OR PARTNER HAS HISTORY OF GENITAL HERPES  |     |    | <ol> <li>HISTORY OF STD, GONORRHEA, CHLAMYDIA, HPV, HIV, SYPHILIS<br/>(CIRCLE ALL THAT APPLY)</li> </ol> |
| 3. RASH OR VIRAL ILLNESS SINCE LAST MENSTRUAL PERIOD |     |    | 6. OTHER (SEE COMMENTS)  |

### **COMMENTS**

## INTERVIEWER'S SIGNATURE \_\_\_\_\_

|                 | INITIAL PHYSICAL EXAMINATION |            |                          |           |                |             |  |  |
|-----------------|------------------------------|------------|--------------------------|-----------|----------------|-------------|--|--|
| DATE /          | _/                           | WEIGHT     | HEIGHT                   | ВМІ В     | P              |             |  |  |
| 1. HEENT        | ☐ NORMAL                     | ☐ ABNORMAL | 12. VULVA                | ☐ NORMAL  | ☐ CONDYLOMA    | ☐ LESIONS   |  |  |
| 2. FUNDI        | ☐ NORMAL                     | ☐ ABNORMAL | 13. VAGINA               | ☐ NORMAL  | ☐ INFLAMMATION | ☐ DISCHARGE |  |  |
| 3. TEETH        | ☐ NORMAL                     | ☐ ABNORMAL | 14. CERVIX               | ☐ NORMAL  | ☐ INFLAMMATION | LESIONS     |  |  |
| 4. THYROID      | ☐ NORMAL                     | ☐ ABNORMAL | 15. UTERUS SIZE          | WEEKS     |                | ☐ FIBROIDS  |  |  |
| 5. BREASTS      | ☐ NORMAL                     | ☐ ABNORMAL | 16. ADNEXA               | ☐ NORMAL  | ☐ MASS         |             |  |  |
| 6. LUNGS        | ☐ NORMAL                     | ☐ ABNORMAL | 17. RECTUM               | □ NORMAL  | ☐ ABNORMAL     |             |  |  |
| 7. HEART        | ☐ NORMAL                     | ☐ ABNORMAL | 18. DIAGONAL CONJUGATE   | ☐ REACHED | □ NO           | CM          |  |  |
| 8. ABDOMEN      | ☐ NORMAL                     | ☐ ABNORMAL | 19. SPINES               | ☐ AVERAGE | ☐ PROMINENT    | ☐ BLUNT     |  |  |
| 9. EXTREMITIES  | ☐ NORMAL                     | ☐ ABNORMAL | 20. SACRUM               | ☐ CONCAVE | ☐ STRAIGHT     | ☐ ANTERIOR  |  |  |
| 10. SKIN        | ☐ NORMAL                     | ☐ ABNORMAL | 21. SUBPUBIC ARCH        | ☐ NORMAL  | ☐ WIDE         | □ NARROW    |  |  |
| 11. LYMPH NODES | ☐ NORMAL                     | ☐ ABNORMAL | 22. GYNECOID PELVIC TYPE | ☐ YES     | □ NO           |             |  |  |

COMMENTS (Number and explain abnormals)

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| DRUG ALLERGY                     | LATEX ALLERGY | ′ □ YES  | □ NO                                |                   |           |
|----------------------------------|---------------|----------|-------------------------------------|-------------------|-----------|
| IS BLOOD TRANSFUSION ACCEPTABLE? | ?             | O ANT    | EPARTUM ANESTHESIA                  | A CONSULT PLANNED | □ YES □ N |
| PROBLEMS/PLANS                   |               |          | MEDICATION LIST<br>(Include Dosage) | Start date        | Stop date |
| 1.                               |               |          | 1.                                  |                   |           |
| 2.                               |               |          | 2.                                  |                   |           |
| 3.                               |               |          | 3.                                  |                   |           |
| 4.                               |               |          | 4.                                  |                   |           |
| 5.                               |               |          | 5.                                  |                   | 11        |
| 6.                               |               |          | 6.                                  |                   |           |
| EDD CONFIRMA                     | TION          |          | 18–2                                | 0-WEEK EDD UPDATE |           |
| LMP/                             | = EDD/        | —'—— FUI | ICKENING/<br>NDAL HT.               |                   | //        |
| INITIAL EXAM/ / =                |               | / AT     | UMBIL/                              |                   |           |
|                                  | WRS = EDD /   | FIN      | AL EDD 1                            |                   |           |
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 $<sup>^{\</sup>mbox{\scriptsize *}}\mbox{Describe the intensity of discomfort ranging from 0 (no pain) to 10 (worst possible pain).}$ 

### LABORATORY AND EDUCATION

| INITIAL LABS                                | DATE       | RESULT  | REVIEWED |
|---|------------|---|----------|
| BLOOD TYPE                                  | 1 1        | A B AB O  |          |
| D (Rh) TYPE                                 | 1 1        |   |          |
| ANTIBODY SCREEN                             | 1 1        |   |          |
| HCT/HGB/MCV                                 | 1 1        | % g/dL  |          |
| PAP TEST                                    | 1 1        | NORMAL/ABNORMAL/  |          |
| VARICELLA                                   |            |   |          |
| RUBELLA                                     | 1 1        |   |          |
| VDRL  | 1 1        |   |          |
| URINE CULTURE/SCREEN                        | 1 1        |   |          |
| HBsAg                                       | 1 1        |   |          |
| HIV COUNSELING/TESTING*                     | <u>į</u> į | POS. NEG. DECLINED                                      |          |
| OPTIONAL LABS                               | DATE       | RESULT  |          |
| HEMOGLOBIN ELECTROPHORESIS                  | Ĭ Ĭ        | AA AS SS AC SC AF TA <sub>2</sub><br>POS. NEG. DECLINED |          |
| PPD   | 1 1        |   |          |
| CHLAMYDIA                                   | 1 1        |   |          |
| GONORRHEA                                   | 1 1        |   |          |
| CYSTIC FIBROSIS                             | 1 1        | POS. NEG. DECLINED                                      |          |
| TAY-SACHS                                   | 1 1        | POS. NEG. DECLINED                                      |          |
| FAMILIAL DYSAUTONOMIA                       | 1 1        | POS. NEG. DECLINED                                      | 7        |
| HEMOGLOBIN                                  |            |   |          |
| GENETIC SCREENING TESTS (SEE FORM B)        | 1/1/       |   |          |
| OTHER                                       |            |   |          |
| 8-20-WEEK LABS (WHEN INDICATED/<br>ELECTED) | DATE       | RESULT  |          |
| ULTRASOUND                                  | 1 F        |   |          |
| 1ST TRIMESTER ANEUPLOIDY RISK<br>ASSESSMENT | 1 1        | POS. NEG. DECLINED                                      |          |
| MSAFP/MULTIPLE MARKERS                      | 1 1        | POS. NEG. DECLINED                                      |          |
| 2ND TRIMESTER SERUM SCREENING               | 1 1        | POS. NEG. DECLINED                                      |          |
| AMNIO/CVS                                   | 1 1        |   |          |
| KARYOTYPE                                   | 1 1        | 46,XX OR 46,XY/OTHER                                    |          |
| AMNIOTIC FLUID (AFP)                        | 1 1        | NORMAL ABNORMAL   |          |
| ANTI-D IMMUNE GLOBULIN (RHIG)               | 1 1        |   |          |

 $<sup>^{*}</sup>$ Check state requirements before recording results.

(CONTINUED)

# ACOG ANTEPARTUM RECORD (FORM D, continued)

## LABORATORY AND EDUCATION (continued)

| 24–28-WEEK LABS (WHEN INDICATED)                           | DATE | RESULT       | COMMENTS/ADDITIONAL LABS |
|--|------|--------------|--------------------------|
| HCT/HGB/MCV  | 1 1  | % g/aL       |                          |
| DIABETES SCREEN  | 1 1  | 1 HOUR       |                          |
| GTT (IF SCREEN ABNORMAL)                                   | 1 1  | FBS1 HOUR    |                          |
|  |      | 2 HOUR3 HOUR |                          |
| D (Rh) ANTIBODY SCREEN                                     | 1 1  |              |                          |
| ANTI-D IMMUNE GLOBULIN (RHIG)<br>GIVEN (28 WKS OR GREATER) | 1 1  | SIGNATURE    |                          |
| 32-36-WEEK LABS  | DATE | RESULT       |                          |
| HCT/HGB  | 1 1  | % g/dL       |                          |
| ULTRASOUND (WHEN INDICATED)                                | 1 1  |              |                          |
| HIV (WHEN INDICATED)*                                      |      |              |                          |
| VDRL (WHEN INDICATED)                                      | 1 1  |              |                          |
| GONORRHEA (WHEN INDICATED)                                 | 1 1  |              |                          |
| CHLAMYDIA (WHEN INDICATED)                                 | 1 1  |              |                          |
| GROUP B STREP  | 1 1  |              |                          |

<sup>\*</sup>Check state requirements before recording results.

| COMMENTS |  |
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| COMPLETED    NEED FOR FURTHER DISCUSSION   FOLLOW-UP IN 3RD TRIMESTER, IF NEEDED | FIRST TRIMESTER COMPLETED FURTHER DISCUSSION  ☐ HIV AND OTHER ROUTINE PRENATAL TESTS ☐ FOLLOW-UP IN 3RD TRIMESTER.   |
|--|--|
| COMPLETED FURTHER DISCUSSION   FOLLOW-UP IN 3RD TRIMESTER, IF NEEDED             | RIST TRIMESTER  HW AND OTHER ROUTINE PRENATAL TISTS  RISK FACTORS IDENTIFIED BY PRENATAL HISTORY  RISK FACTORS IDENTIFIED BY PRENATAL CARE  NUTRITION AND WEIGHT GAIN COUNSELING, SPECIAL DIET  TOXOPLASMOSIS PRECAUTIONS (CATSRAW MEAT)  BY SUBJECT OF TOXOPLASMOSIS PRECAUTIONS (CATSRAW MEAT)  BY SUBJECT OF TOXOPLASMOSIS PRECAUTIONS (CATSRAW MEAT)  BY SUBJECT OF TOXOPLASMOSIS PRECAUTIONS (CATSRAW MEAT)  BY SUBJECT OF TOXOPLASMOSIS PRECAUTIONS (CATSRAW MEAT)  BY SUBJECT OF TOXOPLASMOSIS PRECAUTIONS (CATSRAW MEAT)  BY SUBJECT OF TOXOPLASMOSIS PRECAUTIONS (CATSRAW MEAT)  BY SUBJECT OF TOXOPLASMOSIS PRECAUTIONS (CATSRAW MEAT)  BY SUBJECT OF TOXOPLASMOSIS PRECAUTIONS (CATSRAW MEAT)  BY SUBJECT OF TOXOPLASMOSIS PRECAUTIONS (CATSRAW MEAT)  BY SUBJECT OF TOXOPLASMOSIS PRECAUTIONS (CATSRAW MEAT)  AND SUBJECT OF TOXOPLASMOSIS (CATSRAW MEAT)  DOMESTIC VIOLENCE  SEAT RELIT USE  CHILDISTRY CLASSES SHOSPITAL FACILITIES  SECOND TRIMESTER  SIGNS AND SYMPTOMS OF PRETERM LABOR  ARRORMAL LAB VALUES  BY SUBJECT ON A NEWBORN CARE PROVIDER  SELECTION A NEWBORN CARE PROVIDER  SELECTION A NEWBORN CARE PROVIDER  SELECTION A NEWBORN CARE PROVIDER  DOMESTIC VIOLENCE  SELECTION A NEWBORN CARE PROVIDER  POSTPARTUM FAMILY PLANNINGTURAL STERILIZATION  DOMENTICED  DOMESTIC VIOLENCE  |
| S, HERBS, OR OTO DRUGS)  | □ ANTICIPATED COURSE OF PRENATAL CARE □ NUTRITION AND WEIGHT GAIN COUNSELING. SPECIAL DIET □ TOXOPIA-SMOSIS PRECAUTIONS (CATS/RAW MEAT) □ SEXUAL ACTIVITY □ EXERCISE □ INFLUENZA VACCINE □ SWOKING COUNSELING □ ENVIRONMENTAL/MORK HAZARDS □ ENVIRONMENTAL/MORK HAZARDS □ TRAVEL □ TOBRACCO (ASK, ADVISE, ASSESS, ASSIST, AND ARRANGE) □ LILICIT/RECREATIONAL DRUGS □ LILICIT/RECREATIONAL DRUGS □ LILICIT/RECREATIONAL DRUGS □ USE OF ANY MEDICATIONS (INCLUDING SUPPLEMENTS, VITAMINS, HERBS, OR OTC DRUGS) □ INDICATIONS FOR ULTRASOUND □ DOME-STIC VIOLENCE □ SEAT BELT USE □ CHILDEBIRTH CLASSES/HOSPITAL FACILITIES  **ECOMO TRIMESTER* □ SIGNS AND SYMPTOMS OF PRETERM LABOR  |
| S, HERBS, OR OTC DRUGS)  | □ NUTRITION AND WEIGHT GAIN COUNSELING SPECIAL DIET □ TOXOPLASWOSIS PRECAUTIONS (CATSRAW WEAT) □ SEXUAL ACTIVITY □ EXERCISE □ INFLUENZA VACCINE □ SMOKING COUNSELING □ ENVIRONMENTAL/WORK HAZARDS □ TRAVEL □ TOBACCO (ASK, ADVISE, ASSESS, ASSIST, AND ARRANGE) □ LILICITIRECREATIONAL DRUGS □ LILICITIRECREATIONAL DRUGS □ USE OF ANY MEDICATIONS (INCLUDING SUPPLEMENTS, VITAMINS, HERBS, OR OTO DRUGS) □ INDICATIONS FOR ULTRASCUND □ DOMESTIC VIOLENCE □ SEAT BELT USE □ CHILDEIRTH CLASSES/HOSPITAL FACILITIES SECOND TRIMESTER □ SIGNS AND SYMPTOMS OF PRETERM LABOR □ SIGNS AND SYMPTOMS OF PRETERM LABOR □ SIGNS AND SYMPTOMS OF PRETERM LABOR □ SIGNS AND SYMPTOMS OF PRETERM LABOR □ SIGNS AND SYMPTOMS OF PRETERM LABOR □ SIGNS AND SYMPTOMS OF PRETERM LABOR □ SIGNS AND SYMPTOMS OF PRETERM LABOR □ SIGNS AND SYMPTOMS OF PRETERM LABOR □ SIGNS AND SYMPTOMS OF PRETERM LABOR □ SIGNS AND SYMPTOMS OF PRETERM LABOR □ SIGNS AND SYMPTOMS OF PRETERM LABOR □ SIGNS AND SYMPTOMS OF PRETERM LABOR □ SIGNS AND SYMPTOMS OF PRETERM LABOR □ SIGNS AND SYMPTOMS OF PRETERM LABOR □ SIGNS AND SYMPTOMS OF PRETERM LABOR □ DOMESTIC VIOLENCE □ POSTPARTUM FAMILY PLANNING/TUBAL STERILIZATION  **ONTHWED**  **ON  |
| S, HERBS, OR OTC DRUGS)  | TOXOPLASMOSIS PRECAUTIONS (CATSRAW MEAT)  SEXUAL ACTIVITY  EXERCISE  INFLUENZA VACCINE  SMOKING COUNSELING  ENARCOMMENTALAWORK HAZARDS  TRAMEL  TOBACCO (ASK, ADVISE, ASSESS, ASSIST, AND ARRANGE)  ALCOHOL  ILLICITIFECREATIONAL DRUGS  USE OF ANY MEDICATIONS (INCLUDING SUPPLEMENTS, VITAMINS, HERBS, OR OTC DRUGS)  DOMESTIC VIOLENCE  SEAT BELLT USE  CHILDERITH CLASSE SHOSPITAL FACILITIES  SECOND TRIMESTER  SIGNIS AND SYMPTOMS OF PRETERM LABOR  ABNORMAL LAB VALUES  IMPLENZA VACCINE  SELECTING A NEWBORN CARE PROVIDER  SMOKING COUNSELING  DOMESTIC VIOLENCE  SELECTING A NEWBORN CARE PROVIDER  SMOKING COUNSELING  DOMESTIC VIOLENCE  SMOKING COUNSELING  DOMESTIC VIOLENCE  DOMESTIC VIOLENCE  SMOKING COUNSELING  DOMESTIC VIOLENCE  DOMESTIC VIOLENCE  SMOKING COUNSELING  DOMESTIC VIOLENCE  DOMESTI |
| S, HERBS, OR OTC DRUGS)  | □ SEXUAL ACTIVITY □ EXERCISE □ INFLUENZA VACCINE □ SMOKING COUNSELING □ SMOKING COUNSELING □ TRAVEL □ TOBACCO (ASK, ADVISE, ASSESS, ASSIST, AND ARRANGE) □ ILLICITIRECREATIONAL DRUGS □ ILLICITIRECREATIONAL DRUGS □ ILLICITIRECREATIONS (INCLUDING SUPPLEMENTS, VITAMINS, HERBS, OR OTC DRUGS) □ INDICATIONS FOR ULTRASOUND □ DOMESTIC VIOLENCE □ SEAT BELT USE □ CHILDERITH CLASSE SHOSPITAL FACILITIES  SECOND TRIMESTER □ SIGNS AND SYMPTOMS OF PRETERMILABOR □ ABNORMAL LAB VALUES □ INFLUENZA VACCINE □ SELECTING A NEWBORN CARE PROVIDER □ SMOKING COUNSELING □ DOMESTIC VIOLENCE □ SMOKING COUNSELING □ DOMESTIC VIOLENCE □ POSTPARTLIM FAMILY PLANNINGTUBAL STERILIZATION   |
| S, HERBS, OR OTC DRUGS)  | □ EXERCISE □ INFLUENZA VACCINE □ SMOKING COUNSELING □ EMIROMENTAL WORK HAZARDS □ TRAVEL □ TOBACCO (ASK, ADMSE, ASSESS, ASSIST, AND ARRANGE) □ LILICITIRE CREATIONAL DRUGS □ LILICITIRE CREATIONAL DRUGS □ USE OF ANY MEDICATIONS (INCLUDING SUPPLEMENTS, VITAMINS, HERBS, OR OTC DRUGS) □ INDICATIONS FOR ULTRASCOUND □ DOMESTIC VIOLENCE □ SEAT BELT USE □ CHILDEBITH CLASSES/HOSPITAL FACILITIES  SECOND TRIMESTER □ SIGNS AND SYMPTOMS OF PRETERM LABOR □ ABNORMAL LAB VALUES □ INFLUENZA VACCINE □ SELECTING A NEWBORN CARE PROVIDER □ SELECTING A NEWBORN CARE PROVIDER □ SMOKING GOUNSELING □ DOMESTIC VIOLENCE □ DOMESTIC VIOLENCE □ DOMESTIC VIOLENCE □ POSTPARTUM FAMILY PLANNING/TUBAL STERILIZATION  DOTINUED)  |
| S, HERBS, OR OTC DRUGS)  | □ INFLUENZA VACCINE □ SMOKING COUNSELING □ ENVIRONMENTAL MYORK HAZARDS □ TRAVEL □ TOBACCO (ASK, ADVISE, ASSESS, ASSIST, AND ARRANGE) □ ALCOHOL □ ILLICIT/RECREATIONAL DRUGS □ USE OF ANY MEDICATIONS (INCLUDING SUPPLEMENTS, VITAMINS, HERBS, OR OTO DRUGS) □ INDICATIONS FOR ULTRASOUND □ DOMESTIC VIOLENCE □ SEAT BELT USE □ CHILDBIRTH CLASSES/HOSPITAL FACILITIES  SECOND TRIMESTER □ SIGNS AND SYMPTOMS OF PRETERM LABOR □ ABNORMAL LAB VALUES □ ABRORMAL LAB VALUES □ SELECTING A NEWBORN CARE PROVIDER □ SMOKING COUNSELING □ DOMESTIC VIOLENCE □ POSTPARTIUM FAMILY PLANNING/TUBAL STERILIZATION  DOTTINUED)   |
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|  | SECOND TRIMESTER SIGNS AND SYMPTOMS OF PRETERM LABOR ABNORMAL LAB VALUES INFLUENZA VACCINE SELECTING A NEWBORN CARE PROVIDER SMOKING COUNSELING DOMESTIC VIOLENCE POSTPARTUM FAMILY PLANNING/TUBAL STERILIZATION  DONTINUED)   |
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|  | INFLUENZA VACCINE  SELECTING A NEWBORN CARE PROVIDER  SMOKING COUNSELING  DOMESTIC VIOLENCE  POSTPARTUM FAMILY PLANNING/TUBAL STERILIZATION  ONTINUED)   |
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| PLANS/EDUCATION (continued)<br>(COUNSELED □)—BY TRIMESTER. INITIAL AND DATE WHEN DISCUSSED. |           |                                |
|---|-----------|--------------------------------|
| THIRD TRIMESTER  ☐ ANESTHESIA/ANALGESIA PLANS   | COMPLETED | NEED FOR<br>FURTHER DISCUSSION |
| FETAL MOVEMENT MONITORING   |           |                                |
| ☐ LABOR SIGNS   |           |                                |
| UBAC COUNSELING   |           |                                |
| SIGNS AND SYMPTOMS OF PREGNANCY-INDUCED HYPERTENSION  |           |                                |
| ☐ POSTTERM COUNSELING   |           |                                |
| ☐ CIRCUMCISION  |           |                                |
| ☐ BREAST OR BOTTLE FEEDING  |           |                                |
| □ POSTPARTUM DEPRESSION   |           |                                |
| ☐ INFLUENZA VACCINE   |           |                                |
| ☐ SMOKING COUNSELING  |           |                                |
| ☐ DOMESTIC VIOLENCE   |           |                                |
| ☐ NEWBORN EDUCATION (NEWBORN SCREENING, JAUNDICE, SIDS, CAR SEAT)                           |           |                                |
| ☐ FAMILY MEDICAL LEAVE OR DISABILITY FORMS  |           |                                |
| REQUESTS  |           |                                |
| TUBAL STERILIZATION CONSENT SIGNED DATE IN  | ITIALS    |                                |
| HISTORY AND PHYSICAL HAVE BEEN SENT TO HOSPITAL, IF APPLICABLE.  DATE  IN                   | ITIALS    |                                |
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| Plans/Education Notes |
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# ACOG ANTEPARTUM RECORD (FORM E, continued)

| The state of disconfict ariging from 0 (no pain) to 10 (worst possible pain).  Progress Notes |                               |                              | Supp                  | olementa      | l Visits       |                 |  |
|---|-------------------------------|------------------------------|-----------------------|---------------|----------------|-----------------|--|
| mensity of discomfort ranging from 0 (no pain) to 10 (worst possible pain).                   | NCY                           |                              | // 🗸                  |               | / / , §        | >//             |  |
| mensity of discomfort ranging from 0 (no pain) to 10 (worst possible pain).                   |                               | NON ANDREAL                  |                       |               | dunnicial      |                 | A THE BELLEVIE OF THE PERSON O |
| mensity of discomfort ranging from 0 (no pain) to 10 (worst possible pain).                   | Wild Salar State              |                              |                       | ODE WEIGHT SE | AL INTERIOR OF | Track Mark Mark | E STATE OF THE STA |
| mensity of discomfort ranging from 0 (no pain) to 10 (worst possible pain).                   |                               |                              |                       |               |                |                 | COMMENTS   |
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