UCLA Health System

MRN:
Patient Name:
(Patient Label)

ANTEPARTUM RECORD

Patients, please fill out only the indicated sections.

ŠŒÞÕWŒÕÒ	UÔÔWÚŒ/ŒÞ	PHONE: (Home)	PHONE: (Office)
FATHER OF BABY	EMERGENCY CONTACT	RELATIONSHIP:	PHONE:

TOTAL PREG	FULL TERM	PREMATURE	ABORTIONS INDUCED	ABORTIONS SPONTANEOUS	ECTOPICS	MULTIPLE BIRTHS	LIVING

MENSTRUAL HISTORY

LMP ☐ Definite	☐ Appropriate (Month Known)	MENSES MONTHLY ☐ Yes ☐ No	FREQUENCY: Every ________ Days	MENARCHE ________ (Age Onset)
☐ Unknown	☐ Normal Amount/Duration	PRIOR MENSES ___________ Date	ON BCP'S AT CONCEPT. ☐ Yes ☐ No	hCG+ ______ / _____ / ______

PAST PREGNANCIES (LAST SIX)

DATE MO / YR	GA WEEKS	LENGTH OF LABOR	BIRTH WEIGHT	SEX M / F	TYPE DELIVERY	ANES.	PLACE OF DELIVERY	PRETERM LABOR YES / NO	COMMENTS / COMPLICATIONS

PAST MEDICAL HISTORY

	O Neg + Pos.	Detail Positive Remarks (Include Date & Treatment)			O Neg + Pos.	Detail Positive Remarks (Include Date & Treatment)
1. DIABETES				17. D (Rh) SENSITIZED		
2. HYPERTENSION				18. PULMONARY (ASTHMA, TB)		
3. HEART DISEASE				19. SEASONAL ALLERGIES		
4. AUTOIMMUNE DISORDER				20. DRUG / LATEX ALLERGIES		
5. MITRAL VALVE PROLAPSE				21. GYN SURGERY		
6. KIDNEY DISEASE / UTI						
7. NEUROLOGIC / EPILEPSY				22. BREAST DISEASE OR SURGERY		
8. PSYCHIATRIC				23. OPERATIONS / HOSPITALIZATIONS (Year and Reason)		
9. DEPRESSION / PP DEPRESSION						
10. HEPATITIS / LIVER DISEASE				24. TRAUMA		
11. VARICOSITIES / PHLEBITIS				25. ANESTHETIC COMPLICATIONS		
12. THYROID DISFUNCTION				26. HISTORY OF ABNORMAL PAP		
13. HX BLOOD TRANFUSION				27. UTERINE ANOMALY / DES		
	Amt/Day Prepreg	Amt/Day Preg	# Yrs Use	28. INFERTILITY		
14. TOBACCO				29. ART TREATMENT		
15. ALCOHOL				30. RELEVANT FAMILY HISTORY		
16. ILLICIT/RECREATIONAL DRUGS				31. OTHER		

COMMENTS: ____

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LABORATORY AND EDUCATION

INITIAL LABS	DATE	RESULT	REVIEWED	COMMENTS/ADDITIONAL LAB
BLOOD TYPE	/ /			
D (Rh) TYPE	/ /			
ANTIBODY SCREEN	/ /			
CBC	/ /			
PAP SMEAR	/ /			
VARICELLA TITRE	/ /			
RUBELLA TITRE	/ /			
GONORRHEA	/ /			
CHLAMYDIA	/ /			
URINE CULTURE	/ /			
HbsAg	/ /			
HIV	/ /			
PPD	/ /			
VDRL	/ /			
OTHER	/ /			
OTHER	/ /			
8-18 WEEK LABS (When Indicated)	**DATE**	**RESULT**		
ULTRASOUND	/ /			
FIRST TRIMESTER SCREEN	/ /			
SECOND TRIMESTER SCREEN	/ /			
CVS – KARYOTYPE	/ /			
AMINO – KARYOTYPE	/ /			
OTHER	/ /			
24-28 WEEK LABS (When Indicated)	**DATE**	**RESULT**		
HCT/HGB	/ /			
DIABETES SCREEN	/ /			
GTT (IF SCREEN ABNORMAL)	/ /			
D (Rh) ANTIBODY SCREEN	/ /			
RhIG GIVEN (28 wks)	/ /			
32-36 WEEK LABS (When Indicated)	**DATE**	**RESULT**		
ULTRASOUND	/ /			
CBC	/ /			
GROUP B STREP	/ /			
OTHER	/ /			
OPTIONAL LAB (High-Risk Groups)	**DATE**	**RESULT**		
HGB ELECTROPHORESIS	/ /			
CYSTIC FIBROSIS	/ /			
SPINAL MUSCULAR ATROPHY	/ /			
TAY SACHS	/ /			
TSH	/ /			
OTHER	/ /			

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BLOOD TRANSFUSION ACCEPTABLE ☐ **Yes** ☐ **No**	☐ **LATEX ALLERGY**	☐ **DRUG ALLERGY**	
ANESTHESIA CONSULT PLANNED ☐ **Yes** ☐ **No**	☐ **RESIDENT INVOLVEMENT DISCUSSED**		

PROBLEMS/PLANS	**MEDICATION LIST**:	Start Date	Stop Date
1.	1.		
2.	2.		
3.	3.		
4.	4.		
5.	5.		
6.	6.		
7.	7.		
8.	8.		
9.	9.		
10.	10.		
11.	11.		
12.	12.		
13.	13.		
14.	14.		
15.	15.		

EDD CONFIRMATION	**18-20 WEEK EDD UPDATE**
INITIAL EDD:	QUICKENING: _____ /_____ /_____+ 22 WKS = _____ /_____ /_____
LMP: _____ /_____ /_____ = EDD _____ /_____ /_____	FUNDAL HT. AT UMBIL. _____ /_____ /_____+ 20 WKS = _____ /_____ /_____
INITIAL EXAM: _____ /_____ /_____ = ____ WKS = EDD _____ /_____ /_____	FHT W/FETOSCOPE _____ /_____ /_____+ 20 WKS = _____ /_____ /_____
ULTRASOUND: _____ /_____ /_____ = ____ WKS = EDD _____ /_____ /_____	ULTRASOUND _____ /_____ /_____= ____ WKS = _____ /_____ /_____
INITIAL EDD: _____ /_____ /_____ INITIALED BY: ________________	FINAL EDD _____ /_____ /_____ INITIALED BY: _______________

VISIT DATE (Year ________)																
WEEKS GEST. (Best Est.)																
FUNDAL HEIGHT (CM)																
PRESENTATION																
FHR PRESENT:																
FETAL MOVEMENT: +=PRESENT O=ABSENT																
PRETERM LABOR SIGNS/SYMPTOMS:																
CERVIX EXAM ULTRASOUND LENGTH																
BLOOD PRESSURE	INITIAL															
	REPEAT															
EDEMA																
WEIGHT (Prepreg: _____________)																
CUMULATIVE WEIGHT GAIN																
URINE (Glucose/Albumin)																
NEXT APPOINTMENT																
PROVIDER (Initials)																
TEST REMINDERS		**8-18 WEEKS CVS/AMNIO/MSAFP**					**24-28 WEEKS GLUCOSE SCREENING**									

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GENETICS SCREENING

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

	YES	NO		YES	NO
1. PATIENT'S AGE ≥ 35 YEARS			12. HUNTINGTON CHOREA		
2. THALASSEMIA (Italian, Greek, Mediterranean, or Asian Background); MCV < 80			13. MENTAL RETARDATION		
3. NEUTRAL TUBE DEFECT (Meningomyelocele, Open Spine, or Anencephaly)			IF YES, WAS PERSON TESTED FOR FRAGILE X?		
4. CONGENITAL HEART DEFECT			14. OTHER INHERITED GENETIC OR CHROMOSOMAL DISORDER		
5. DOWN SYNDROME			15. MATERNAL METABOLIC DISORDER (TYPE 1 DM, PKU)		
6. TAY-SACHS (Ashkenazi Jewish, French Canadian, Cajun)			16. PATIENT OR BABY'S FATHER HAD A CHILD WITH BIRTH DEFECTS NOT LISTED ABOVE		
7. CANAVAN Disease, FAMILIAL DYSAUTONOMIA (Ashkenazi Jewish)			17. RECURRENT PREGNANCY LOSS OR STILL BIRTH		
8. SICKLE CELL DISEASE OR TRAIT (AFRICAN)			18. MEDICATIONS, ALCOHOL, OR DRUGS SINCE LMP (including supplements, vitamins, herbs or OTC drugs)		
9. HEMOPHILIA OR OTHER BLOOD DISORDER			IF YES, AGENT(s):		
10. MUSCULAR DYSTROPHY			19. ANY OTHER:		
11. CYSTIC FIBROSIS					

COMMENTS: ______________________________

INFECTION HISTORY

	YES	NO		YES	NO
1, LIVE WITH SOMEONE WITH TB OR EXPOSED TO TB			5. HISTORY OF STD, GC, CHLAMYDIA, HPV, SYPHILIS		
2. PATIENT OR PARTNER AS HISTORY OF GENTIAL HERPES			6. HIGH RISK FOR HIV		
3. RASH OR VIRAL ILLNESS SINCE LAST MENSTRUAL PERIOD.			7. OTHER:		
4. HIGH RISK FOR HEPATITIS-C					

COMMENTS: ______________________________

______________________________ INTERVIEWER'S SIGNATURE ______________________________

INITIAL PHYSICAL EXAMINATION

DATE ______ / ______ /_______ PRE PREGNANCY WEIGHT ________ HEIGHT ______________ BP ____________

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	☐ NORMAL	☐ ABNORMAL	☐ 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. ARCH	☐ NORMAL	☐ WIDE	☐ NARROW
11. LYMPH NODES	☐ NORMAL	☐ ABNORMAL	22. GYNECOID PELVIC TYPE	☐ YES	☐ NO	

COMMENTS: (Number and explain abnormals): ______________________________

______________________________ EXAM BY ______________________________

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PLANS/EDUCATION ☐ INITIAL AND DATE WHEN DISCUSSED

FIRST TRIMESTER	NEED FOR FURTHER DISCUSSION
☐ RESIDENT INVOLVEMENT	
☐ HIV AND OTHER ROUTINE PRENATAL TESTS	
☐ RISK FACTORS IDENTIFIED BY PRENATAL HISTORY	
☐ ANTICIPATED COURSE OF PRENATAL CARE	
☐ NUTRITION AND WEIGHT GAIN COUNSELING	
☐ TOXOPLASMOSIS PRECAUTIONS (Cats/Raw Meat)	
☐ SEXUAL ACTIVITY	
☐ EXERCISE	
☐ VACCINES (Tdap, Influenza, H1N1)	
☐ SMOKING COUNSELING	
☐ ENVIRONMENTAL HAZARDS	
☐ TRAVEL	
☐ TOBACCO (Ask, Advise, Assess, Assist, Arrange)	
☐ ALCOHOL	
☐ DRUGS	
☐ USE OF MEDICATIONS, SUPPLEMENTS, VITAMINS	
☐ INDICATIONS FOR ULTRASOUND	
☐ DOMESTIC VIOLENCE	
☐ SEAT BELT USE	
☐ CHILDBIRTH CLASSES/HOSPITAL FACILITIES	
SECOND TRIMESTER	
☐ SIGNS AND SYMPTOMS OF PRETERM LABOR	
☐ ABNORMAL LAB VALUES	
☐ SELECTING A NEWBORN CARE PROVIDER	
☐ POSTPARTUM FAMILY PLANNING/TUBAL STERILIZATION	
THIRD TRIMESTER	
☐ CHILDBIRTH CLASSES	
☐ ANESTHESIA PLANS	
☐ FETAL MOVEMENT MONITORING	
☐ LABOR SIGNS	
☐ VBAC COUNSELING	
☐ SIGNS/SYMPTOMS OF PREGNANCY INDUCED HYPERTENSION	
☐ POST TERM COUNSELING	
☐ CIRCUMCISION	
☐ BREASTFEEDING	
☐ POST PARTUM DEPRESSION	
☐ NEWBORN EDUCATION (SIDS, CAR SEAT)	
☐ FAMILY MEDICAL LEAVE OR DISABILITY FORMS	

TUBAL STERILIZATION ☐ DESIRED

CONSENT SIGNED: ________ / ______ / ______ INITIALS: _______

PROVIDER SIGNATURE: ____ PAGER: _________________

PRINT NAME: ____ DATE: ______________ TIME: _______