The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

Patient Addressograph

Date: — — ID #:

Hospital of Delivery:

ANTEPARTUM RECORD

Name: _____
LAST FIRST MIDDLE

Newborn Care Provider:	Referred By:
Primary Care Provider/Group:	Address:
Final EDD:	
Birth Date: — — Age: Race: Marital Status: S M W D Sep	Address:
	Zip: Phone: (1) (2)
Occupation: Education: (Last Grade Completed)	E-Mail:
Language: Ethnicity:	Insurance Carrier/Medicaid #:
Partner: Phone:	Policy #:
Father Of Baby: Phone:	Emergency Contact: Phone:

Total Preg:	Full Term:	Premature:	Ab, Induced:	Ab, Spontaneous:	Ectopics:	Multiple Births:	Living:

Menstrual History

Lmp ☐ Definite ☐ Approximate (Month Known) ☐ Unknown ☐ Normal Amount/Duration ☐ Final: _____

Duration: Q _____ Days

Prior Menses: _____ Date

Frequency: Q _____ Days

Contraception at conception ☐ Yes ☐ No

Menarche: _____ (Age Onset)

Hcg + ___/___/___

Past Pregnancies (Last Five)

Date Month/ Year	GA Weeks	Length Of Labor	Birth Weight	Sex M/F	Type Of Delivery	Anes	Place Of Delivery	Breastfeeding Duration	Lactation Consult Needed Yes/No	Comments/ Complications

Medical History

	P*	F*	Detail Positive Remarks Include Date & Treatment
A. Drug/Latex Allergies/ Reactions B. Allergies (Food, Seasonal, Environmental)			
1. Neurologic/Epilepsy			
2. Thyroid Dysfunction			
3. Breast Disease/Breast Surgery			
4. Pulmonary (TB, Asthma)			
5. Heart Disease			
6. Hypertension			
7. Cancer			
8. Hematologic Disorders			
9. Anemia			
10. Gastrointestinal Disorders			
11. Hepatitis/Liver Disease			
12. Kidney Disease/UTI			
13. Deep Vein Thrombosis			
14. Diabetes (Type 1 Or Type 2)			
15. Gestational Diabetes			
16. Autoimmune Disorders			

	P*	F*	Detail Positive Remarks Include Date & Treatment
17. Dermatologic Disorders			
18. Operations/Hospitalizations (Year & Reason)			
19. Gyn Surgery (Year & Reason)			
20. Anesthetic Complications			
21. History Of Blood Transfusions			
22. Infertility			
23. Art (IVF Or FET)			
24. History of Abnormal Pap			
25. History of STI			
26. Psychiatric Illness			
27. Depression/Postpartum Depression			
28. Trauma/Violence			
29. Tobacco (Smoked, Chewed, ENDS, Vaped) (AMT/Day)			
30. Alcohol (AMT/Wk)			
31. Drug Use (Including Opioids) (Uses/Wk)			
32. Polycystic Ovary Syndrome			
33. Other			

Prepreg	Preg	# Years Use

*P= Personal F= Family

COMMENTS: _____

Patient Name:		Birth Date: – –	ID No.:	Date: – –

Genetic Screening*

Condition	Patient	Partner	Other	Relationship
Congenital Heart Defect				
Neural Tube Defect				
Hemoglobinopathy Or Carrier				
Cystic Fibrosis				
Chromosome Abnormality				
Tay–Sachs				
Hemophilia				
Intellectual Disability/Autism				
Recurrent Pregnancy Loss/Stillbirth				
Other Structural Birth Defect				
Other Genetic Disease (eg, PKU, Metabolic Disease, Muscular Dystrophy)				

Teratogen Exposures Since LMP/Conception

	Yes	No	Details/Date
Prescription Medications			
Over The Counter Medications			
Alcohol			
Illicit Drugs			
Maternal Diabetes			HGB A1C
Other			
Uterine Anomaly/DES			

*If a patient has been screened for a genetic disorder previously, the results should be documented but the test should not be repeated.

COMMENTS/COUNSELING: _____

Infection History

	Yes	No
1. Live with Someone with TB or Exposed to TB		
2. Patient or Partner has History of Genital Herpes		
3. Rash or Viral Illness Since Last Menstrual Period		
4. Prior GBS-Infected Child		
5. History of STIS: (Check All That Apply) ☐ Gonorrhea ☐ Chlamydia ☐ HPV ☐ Syphilis ☐ PID		

	Yes	No
6. HIV Infection		
7. History Of Hepatitis		
8. Recent Travel History Outside Of Country		
9. Other (See Comments)		

COMMENTS: _____

INTERVIEWER'S SIGNATURE: _____

Immunizations

Immunizations	Yes (Month/Year) ____ / ____	No	If No, Vaccine Indicated?*	Immunizations	Yes (Month/Year) ____ / ____	No	If No, Vaccine Indicated?*
TDAP (Each pregnancy; between 27–36 weeks)				Hepatitis A (When Indicated)			
Influenza† (Each pregnancy as soon as vaccine is available)				Hepatitis B (When Indicated)			
Varicella†				Meningococcal (When Indicated)			
MMR (Rubella-containing vaccine)†				Pneumococcal (When Indicated)			
HPV							

*Yes/No & date to be administered

†All live vaccines are contraindicated in pregnancy, including the live intranasal influenza, MMR, and varicella vaccines. All women who will be pregnant during influenza season (October through May) should receive inactivated influenza vaccine at any point in gestation. Administer the HPV, MMR, and varicella vaccines postpartum if needed. The Tdap vaccine can be given postpartum if the woman has never received it as an adult and did not get it during pregnancy.

Initial Physical Examination

Date: _____ / _____ / _____ BP/Prepregnancy Weight: _____ Height: _____ BMI: _____

1. Heent		Normal		Abnormal	11. Vulva		Normal		Condyloma		Lesions
2. Teeth		Normal		Abnormal	12. Vagina		Normal		Inflammation		Discharge
3. Thyroid		Normal		Abnormal	13. Cervix		Normal		Inflammation		Lesions
4. Breasts		Normal		Abnormal	14. Uterus Size	___	Weeks				Fibroids
5. Lungs		Normal		Abnormal	15. Adnexa		Normal		Mass		
6. Heart		Normal		Abnormal	16. Rectum		Normal		Abnormal		
7. Abdomen		Normal		Abnormal	17. Clinical Pelvimetry		Concerns		No Concerns		
8. Extremities		Normal		Abnormal							
9. Skin		Normal		Abnormal							
10. Lymph Nodes		Normal		Abnormal							

COMMENTS (Number and explain abnormals): _____

EXAM BY: _____