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:	Ectopic Pregnancy:	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 pregnancy ☐ 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	☐	☐	
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: _____

ANTEPARTUM RECORD (FORM A, page 1 of 12)

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/Pregnancy

	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 or Partner Travel Outside of Country		
9. Recent Exposure to Zika Virus, Including by Partner. Assess at each prenatal visit. Check cdc.gov/zika for updates.		
10. Other (See Comments)		

COMMENTS: _____

INTERVIEWER'S SIGNATURE: _____

Immunizations	Yes (Month/Year) ____ / ____	No	If No, Vaccine Indicated?*
Tdap (Each pregnancy; as early in the 27–36-weeks-of-gestation window as possible)			
Influenza† (Each pregnancy as soon as vaccine is available)			
Varicella†			
MMR (Rubella-containing vaccine)†			
HPV			

Immunizations	Yes (Month/Year) ____ / ____	No	If No, Vaccine Indicated?*
Hepatitis A (When Indicated)			
Hepatitis B (When Indicated)			
Meningococcal (When Indicated)			
Pneumococcal (When Indicated)			

*Yes/No and 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: _____

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

Drug Allergy:_____ Latex Allergy ☐ Yes ☐ No Postpartum Contraception Method:_____
Counseled About LARC? ☐ Yes ☐ No

Is Blood Transfusion Acceptable? ☐ Yes ☐ No Antepartum Anesthesia Consult Planned ☐ Yes ☐ No

Problems	Plans	Resolved?
1.		
2.		
3.		
4.		
5.		

Medication List (Including Opioids)	Start Date	Stop Date
1.	– –	– –
2.	– –	– –
3.	– –	– –
4.	– –	– –
5.	– –	– –

EDD Confirmation

Lmp:	– –	=		= EDD	– –	Prepregnancy Weight	
Initial Exam:	– –	=		Wks = EDD	– –	Height	
Ultrasonography:	– –	=		Wks = EDD	– –	BMI	
Final EDD:	– –	IVF Transfer:			– –	Estimated Weight Gain	
Initialed By:						Recommended Weight Gain	

Prepregnancy Weight _____

BMI _____

Date	Weeks Gest. (Best Est.)	Weight	Blood Pressure	Urine (Albumin/Glucose)	Pain Scale * (0–10)	Fetal Movement	Preterm Labor Signs/Symptoms: *=Present O=Absent	FHR	Fundal Height (CM)/EFW	Presentation	Edema	Cervix Examination (DIL./EFF. STA.) Length On Ultrasonography	Recent Travel or Partner Travel History Outside of Country	Next Appointment	Provider (Initials)	Comments:
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*Describe the intensity of discomfort ranging from 0 (no pain) to 10 (worst possible pain).

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

Laboratory and Screening Tests*

Initial Labs	Date	Result	Reviewed
Blood Type	– –	A ☐ B ☐ AB ☐ O ☐	
D (Rh) Type	– –		
Antibody Screen	– –		
Complete Blood Count	– –	HCT/HGB: _____ % _____ g/dL MCV:_____ PLT:_____	
VDRL/RPR (Syphilis)	– –		
Urine Culture/Screen	– –		
HBsAg	– –		
HIV Testing	– –	Pos. ☐ Neg. ☐ Declined ☐	
Chlamydia	– –		
Gonorrhea (When Indicated)	– –		
Rubella Immunity	– –		
Other:			

Supplemental Labs	Date	Result	
Hemoglobin Electrophoresis	– –	AA ☐ AS ☐ SS ☐ AC ☐	
PPD/Quanta (When Indicated)	– –		
Pap Test (When Indicated)	– –		
HPV (When Indicated)	– –		
Early Diabetes Screen (When Indicated)	– –	Pos. ☐ Neg. ☐ Declined ☐	
Varicella Immunity (When Indicated)	– –		
Cystic Fibrosis	– –	Pos. ☐ Neg. ☐ Declined ☐	
Spinal Muscular Atrophy	– –	Pos. ☐ Neg. ☐ Declined ☐	
Fragile X	– –	Pos. ☐ Neg. ☐ Declined ☐	
Tay–Sachs	– –	Pos. ☐ Neg. ☐ Declined ☐	
Canavan Disease	– –	Pos. ☐ Neg. ☐ Declined ☐	
Familial Dysautonomia	– –	Pos. ☐ Neg. ☐ Declined ☐	
Genetic Screening Tests (See Form B)	– –	Pos. ☐ Neg. ☐ Declined ☐	
Zika Virus (When Indicated, All Trimesters)†	– –		
Other:			

8–20-Week Aneuploidy Screening	Date Test Performed	Result
Aneuploidy Screening Offered	– –	Accepted ☐ Declined ☐ GA Too Advanced ☐
1st Trimester Aneuploidy Screening	– –	Pos ☐ Neg ☐
2nd Trimester Serum Screening	– –	Pos ☐ Neg ☐
Integrated Screening	– –	Pos ☐ Neg ☐
Cell-Free DNA	– –	Pos ☐ Neg ☐
CVS	– –	Karyotype: 46,XX Or 46,XY/Other_____ Array
Amniocentesis	– –	Karyotype: 46,XX Or 46,XY/Other_____ Array
Amniotic Fluid (AFP)	– –	Normal ☐ Abnormal ☐
Other:		

Comments/Additional Labs

(continued)

*For serologic test results, rubella status, hepatitis B results, HIV status, GBS, Zika, and other maternal test results that are relevant to neonatal care, please attach lab results

†Check cdc.gov/zika for updates.

PROVIDER SIGNATURE (AS REQUIRED): _____

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

Laboratory and Screening Tests *(continued)*

Late Pregnancy Labs and Screening	Date	Result	Reviewed
Complete Blood Count	– –	HCT/HGB:_____ % _____ g/dL MCV:_____ PLT:_____	
Diabetes Screen (24–28 Weeks)	– –		
GTT (If Screen Abnormal)	– –	☐ Fbs ☐ 1 Hour ☐ 2 Hours ☐ 3 Hours	
D (Rh) Antibody Screen (When Indicated)	– –		
Anti-D Immune Globulin (RhIg) Given (28 Wks Or Greater) (When Indicated)	– –	_____ Signature	
Ultrasonography (18–24 Weeks) (When Indicated)	– –		
HIV (When Indicated)‡	– –		
VDRL/RPR (Syphilis) (When Indicated)	– –		
Gonorrhea (When Indicated)	– –		
Chlamydia (When Indicated)	– –		
Group B Strep (35–37 Weeks)	– –		
Resistance Testing If Penicillin Allergic	– –		
Other:			

Comments/Additional Labs

‡Check state requirements before recording results.

Comments

PROVIDER SIGNATURE (AS REQUIRED): _____

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

Plans/Education/Screening

By Trimester. Initial And Date When Discussed.

	NA	Date	Follow-Up Needed	Referral	Comments
First Trimester					
Screening					
Zika Assessment, Testing (When Indicated), And Counseling*		– –			
Psychosocial Screening					
Desire For Pregnancy		– –			
Depression / Anxiety (Should Be Performed At Least Once During Perinatal Period)		– –			
Alcohol		– –			
Tobacco (Smoked, Chewed, ENDS, Vaped) Cessation Counseling (Ask, Advise, Assess, Assist, And Arrange)		– –			
Illicit/Recreational Drugs/Substance Use (Parents, Partner, Past, Present)†		– –			
Intimate Partner Violence		– –			
Barriers To Care		– –			
Unstable Housing		– –			
Communication Barriers		– –			
Nutrition		– –			
Wic Referral					
Environmental/Work Hazards		– –			
Anticipatory Guidance					
Anticipated Course Of Prenatal Care		– –			
Nutrition Counseling; Special Diet; Dietary Precautions (Mercury, Listeriosis)		– –			
Weight Gain Counseling		– –			
Toxoplasmosis Precautions (Cats/Raw Meat)		– –			
Use Of Any Medications (Including Supplements, Vitamins, Herbs, Or Otc Drugs)		– –			
Sexual Activity		– –			
Exercise		– –			
Dental Care/Refer to Dentist		– –			
Avoidance Of Saunas Or Hot Tubs		– –			
Seat Belt Use		– –			
Childbirth Classes/Hospital Facilities		– –			
Breastfeeding		– –			
Fetal Testing					
Indications For Ultrasonography		– –			
Screening For Aneuploidy		– –			
Second Trimester					
Screening					
Zika Assessment, Testing (When Indicated), And Counseling†		– –			
Anticipatory Guidance					
Signs And Symptoms Of Preterm Labor		– –			
Selecting A Newborn Care Provider		– –			
Reproductive Life Planning & Contraception		– –			
Postpartum Care Planning		– –			
Psychosocial Screening					
Tobacco (Smoked, Chewed, ENDS, Vaped) Cessation Counseling (Ask, Advise, Assess, Assist, And Arrange)		– –			
Depression / Anxiety (Should Be Performed At Least Once During Perinatal Period)		– –			
Intimate Partner Violence		– –			

*Check cdc.gov/zika for updates.

†Data from Ewing H. A practical guide to intervention in health and social services with pregnant and postpartum addicts and alcoholics: theoretical framework, brief screening tool, key interview questions, and strategies for referral to recovery resources. Martinez (CA): The Born Free Project, Contra Costa County Department of Health Services; 1990.

(continued)

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

Plans/Education/Screening *(continued)*

By Trimester. Initial and Date When Discussed.

	NA	Date	Follow-Up Needed	Referral	Comments
Third Trimester					
Screening					
Zika Assessment, Testing (When Indicated), And Counseling†	☐	– –			
Birth Preferences					
Pain Management Plans	☐	– –			
Trial Of Labor After Cesarean Counseling	☐	– –			☐ TOLAC ☐ Elective RCS
Labor Support Person(s)	☐	– –			
Immediate Postpartum LARC	☐	– –			☐ Implant ☐ LNG-IUS ☐ Copper IUD
Circumcision Preference	☐	– –			☐ Yes ☐ No
Infant Feeding Intention	☐	– –			☐ Exclusive ☐ Mixed ☐ Formula
Anticipatory Guidance					
Fetal Movement Monitoring	☐	– –			
Signs And Symptoms Of Preeclampsia	☐	– –			
Labor Signs	☐	– –			
Cervical Ripening/Labor Induction Counseling	☐	– –			
Postterm Counseling	☐	– –			
Infant Feeding	☐	– –			
Newborn Education (Newborn Screening, Immunizations, Jaundice, SIDS/Safe Sleeping Position, Car Seat)	☐	– –			
Family Medical Leave Or Disability Forms	☐	– –			
Postpartum Depression	☐	– –			
Psychosocial Screening					
Tobacco (Smoked, Chewed, ENDS, Vaped) Cessation Counseling (Ask, Advise, Assess, Assist, And Arrange)	☐	– –			
Depression / Anxiety (Should Be Performed At Least Once During Perinatal Period)	☐	– –			
Intimate Partner Violence	☐	– –			
Postpartum					
Screening					
Depression / Anxiety (Should Be Performed At Least Once During Perinatal Period)	☐	– –			
Infant Feeding Problems	☐	– –			
Birth Experience	☐	– –			
Glucose Screen (If GDM)	☐	– –			
Zika Assessment, Testing (When Indicated), And Counseling†	☐	– –			
Anticipatory Guidance	☐				
Infant Feeding	☐	– –			
Pelvic Muscle Exercise/Kegel	☐	– –			
Return To Work / Milk Expression	☐	– –			
Weight Retention	☐	– –			
Optimal Birth Spacing	☐	– –			
Postpartum Sexuality	☐	– –			
Exercise	☐	– –			
Nutrition	☐	– –			
Cardiometabolic Risk (If GDM/Gestational Hypertension)	☐	– –			
Transition Of Care					
Referral Made To Primary Care Provider	☐	– –			
Pregnancy Complications Documented In Medical Record	☐	– –			
Written Recommendations For Follow-Up Communicated To Patient And To PCP	☐	– –			

†Check cdc.gov/zika for updates.

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

Plans/Education/Screening *(continued)*

By Trimester. Initial and Date When Discussed.

Requests

	Date	Initials	
Tubal Sterilization Consent Signed (If Desired).	– –		
History And Physical Have Been Sent To Hospital, If Applicable.	– –		
Update With Group B Streptococcus Results Sent.	– –		
Update With HIV Results Sent.	– –		
Update With Zika Results Sent.	– –		
Update With Hepatitis B Results Sent.	– –		
Update With Rubella Results Sent.	– –		
Update With Other Maternal Results Sent (Specify).	– –		

Comments

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

PLANS/EDUCATION/SCREENING NOTES

Name:

LAST FIRST MIDDLE

ID#: EDD:

Prenatal Visits

Prepregnancy Weight

BMI

Date	Weeks Gest. (Best Est.)	Weight	Blood Pressure	Urine (Albumin/Glucose)	Pain Scale* (0–10)	Fetal Movement	Preterm Labor Signs/Symptoms: +=Present O=Absent	FHR	Fundal Height (CM)/EFW	Presentation	Edema	Cervix Examination (DIL./EFF. STA.) Length On Ultrasonography	Recent Travel or Partner Travel History Outside of Country	Next Appointment	Provider (Initials)	**Comments:**
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*Describe the intensity of discomfort ranging from 0 (no pain) to 10 (worst possible pain).

Progress Notes

PROVIDER SIGNATURE (AS REQUIRED): _____

Name:
LAST FIRST MIDDLE

ID#: EDD:

Prenatal Visits

Prepregnancy Weight

BMI

Date	Weeks Gest. (Best Est.)	Weight	Blood Pressure	Urine (Albumin/Glucose)	Pain Scale* (0–10)	Fetal Movement	Preterm Labor Signs/Symptoms: +=Present O=Absent	FHR	Fundal Height (CM)/EFW	Presentation	Edema	Cervix Examination (DIL./EFF. STA.) Length On Ultrasonography	Recent Travel or Partner Travel History Outside of Country	Next Appointment	Provider (Initials)	**Comments:**
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Progress Notes

PROVIDER SIGNATURE (AS REQUIRED): _____

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

Progress Notes

PROVIDER SIGNATURE (AS REQUIRED): _____

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