

DATE _____
 NAME _____
 LAST FIRST MIDDLE
 ID # _____ HOSPITAL OF DELIVERY _____
 NEWBORN'S PHYSICIAN _____ REFERRED BY _____

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 MODESTO, CA 95356
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 Fax (209) 543-7403

FINAL EDD _____ PRIMARY PROVIDER/GROUP _____

BIRTH DATE MONTH DAY YEAR	AGE	RACE	MARITAL STATUS S M W D SEP	ADDRESS:			
OCCUPATION <input type="checkbox"/> HOMEMAKER <input type="checkbox"/> OUTSIDE WORK <input type="checkbox"/> STUDENT Type of Work	EDUCATION (LAST GRADE COMPLETED)			ZIP: _____ PHONE: _____ (H) _____ (O) _____ INSURANCE CARRIER/MEDICAID # _____			
HUSBAND/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 _____
 MENSES MONTHLY YES NO FREQUENCY: Q _____ DAYS MENARCHE _____ (AGE ONSET)
 PRIOR MENSES _____ DATE ON BCP AT CONCEPT. YES NO hCG + ____/____/____

PAST PREGNANCIES (LAST SIX)

DATE MONTH / YEAR	GA WEEKS	LENGTH OF LABOR	BIRTH WEIGHT	SEX MF	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			16. D (Rh) SENSITIZED	
2. HYPERTENSION			17. PULMONARY (TB, ASTHMA)	
3. HEART DISEASE			18. ALLERGIES (DRUGS)	
4. AUTOIMMUNE DISORDER			19. BREAST	
5. KIDNEY DISEASE / UTI			20. GYN SURGERY	
6. NEUROLOGIC/EPILEPSY			21. OPERATIONS / HOSPITALIZATIONS (YEAR & REASON)	
7. PSYCHIATRIC				
8. HEPATITIS / LIVER DISEASE			22. ANESTHETIC COMPLICATIONS	
9. VARICOSITIES / PHLEBITIS			23. HISTORY OF ABNORMAL PAP	
10. THYROID DYSFUNCTION			24. UTERINE ANOMALY/DES	
11. TRAUMA/DOMESTIC VIOLENCE			25. INFERTILITY	
12. HISTORY OF BLOOD TRANSFUS.			26. RELEVANT FAMILY HISTORY	
	AMT/DAY PREPREG	AMT/DAY PREG	#YEARS USE	27. OTHER
13. TOBACCO				
14. ALCOHOL				
15. STREET DRUGS				

COMMENTS: _____

SYMPTOMS SINCE LMP

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GENETIC SCREENING/TERATOLOGY COUNSELING					
INCLUDES PATIENT, BABY'S FATHER, OR ANYONE IN EITHER FAMILY WITH:					
	YES	NO		YES	NO
1. PATIENT'S AGE ≥ 35 YEARS			12. MENTAL RETARDATION/AUTISM		
2. THALASSEMIA (ITALIAN, GREEK, MEDITERRANEAN, OR ASIAN BACKGROUND); MCV < 80			IF YES, WAS PERSON TESTED FOR FRAGILE X?		
3. NEURAL TUBE DEFECT (MENINGOMYELOCELE, SPINA BIFIDA, OR ANENCEPHALY)			13. OTHER INHERITED GENETIC OR CHROMOSOMAL DISORDER		
4. CONGENITAL HEART DEFECT			14. MATERNAL METABOLIC DISORDER (EG. INSULIN-DEPENDENT DIABETES, PKU)		
5. DOWN SYNDROME			15. PATIENT OR BABY'S FATHER HAD A CHILD WITH BIRTH DEFECTS NOT LISTED ABOVE		
6. TAY-SACHS (EG. JEWISH, CAJUN, FRENCH CANADIAN)			16. RECURRENT PREGNANCY LOSS, OR A STILLBIRTH		
7. SICKLE CELL DISEASE OR TRAIT (AFRICAN)			17. MEDICATIONS/STREET DRUGS/ALCOHOL SINCE LAST MENSTRUAL PERIOD		
8. HEMOPHILIA			IF YES, AGENT(S):		
9. MUSCULAR DYSTROPHY			18. ANY OTHER		
10. CYSTIC FIBROSIS					
11. HUNTINGTON CHOREA					

COMMENTS/COUNSELING: _____

INFECTION HISTORY		YES	NO	YES	NO
1. HIGH RISK HEPATITIS B/IMMUNIZED?				4. RASH OR VIRAL ILLNESS SINCE LAST MENSTRUAL PERIOD	
2. LIVE WITH SOMEONE WITH TB OR EXPOSED TO TB				5. HISTORY OF STD, GC, CHLAMYDIA, HPV, SYPHILIS	
3. PATIENT OR PARTNER HAS HISTORY OF GENITAL HERPES				6. OTHER (SEE COMMENTS)	

COMMENTS: _____

INTERVIEWER'S SIGNATURE _____

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

COMMENTS (Number and explain abnormal): _____

EXAM BY _____

ACOG ANTEPARTUM RECORD (FORM B)

LABORATORY AND EDUCATION

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INITIAL LABS	DATE	RESULT	REVIEWED
BLOOD TYPE	/ /	A B AB O	
D (Rh) TYPE	/ /		
ANTIBODY SCREEN	/ /		
HCT/HGB	/ /	_____ % _____ g/dL	
PAP TEST	/ /	NORMAL / ABNORMAL / _____	
RUBELLA	/ /		
VDRL	/ /		
URINE CULTURE/SCREEN	/ /		
HBsAg	/ /		
HIV COUNSELING/TESTING	/ /	<input type="checkbox"/> POS. <input type="checkbox"/> NEG. <input type="checkbox"/> DECLINED	
OPTIONAL LABS	DATE	RESULT	
HGB ELECTROPHORESIS	/ /	AA AS SS AC SC AF T _a	
PPD	/ /		
CHLAMYDIA	/ /		
GC	/ /		
TAY-SACHS	/ /		
OTHER			
8-18-WEEK LABS (WHEN INDICATED/ELECTED)	DATE	RESULT	
ULTRASOUND	/ /		
MSAFP/MULTIPLE MARKERS	/ /		
AMNIO/CVS	/ /		
KARYOTYPE	/ /	46, XX OR 46, XY / OTHER _____	
AMNIOTIC FLUID (AFP)	/ /	NORMAL _____ ABNORMAL _____	
24-28-WEEK LABS (WHEN INDICATED)	DATE	RESULT	
HCT/HGB	/ /	_____ % _____ g/dL	
DIABETES SCREEN	/ /	1 HOUR _____	
GTT (IF SCREEN ABNORMAL)	/ /	_____ FBS _____ 1 HOUR _____ 2 HOUR _____ 3 HOUR	
D (Rh) ANTIBODY SCREEN	/ /		
D IMMUNE GLOBULIN (RNG) GIVEN (28 WKS)	/ /	SIGNATURE _____	
32-36-WEEK LABS (WHEN INDICATED)	DATE	RESULT	
HCT/HGB (RECOMMENDED)	/ /	_____ % _____ g/dL	
ULTRASOUND	/ /		
VDRL	/ /		
GC	/ /		
CHLAMYDIA	/ /		
GROUP B STREP (35-37 WKS)	/ /		

COMMENTS/ADDITIONAL LABS

PLANS/EDUCATION (COUNSELED)

- ANESTHESIA PLANS _____
- TOXOPLASMOSIS PRECAUTIONS (CATS/RAW MEAT) _____
- CHILDBIRTH CLASSES _____
- PHYSICAL/SEXUAL ACTIVITY _____
- LABOR SIGNS _____
- NUTRITION COUNSELING _____
- BREAST OR BOTTLE FEEDING _____
- NEWBORN CAR SEAT _____
- POSTPARTUM BIRTH CONTROL _____
- ENVIRONMENTAL/WORK HAZARDS _____

- TUBAL STERILIZATION _____
- VBAC COUNSELING _____
- CIRCUMCISION _____
- TRAVEL _____
- LIFESTYLE, TOBACCO, ALCOHOL _____

REQUESTS _____

TUBAL STERILIZATION **DATE** **INITIALS**

CONSENT SIGNED _____/_____/_____ _____

PROVIDER SIGNATURE (AS REQUIRED) _____