GREENVILLE MIDWIFERY CARE

PRENATAL CARE RECORD (Page 1 of 3)

NAME: _____

MR#: _____

Your age:	**Race:**	**Phone (primary):** _____ **Other:** _____	
Your DOB:	**Country of birth:**	**Email:**	
Religious practices / cultural or ethnic considerations:			
Highest level of education:		**Name of partner / father of baby (FOB):**	
Occupation: **Primary care provider / Phone:**		**Relationship status:** ☐Married to father of baby ☐Living with father of baby in a long-term committed relationship ☐Single, father of baby not involved ☐Single, father of baby involved, supportive ☐Divorced ☐Widowed ☐Other: _____	
Dentist / Phone:		**FOB's age:**	**Race:** / **Occupation:**
		Phone (primary):	**Phone (other):**

Name of other emergency contact: _____ **Phone:** _____ **Relationship:** _____	**Ages, names, and health status of FOB's other children (if applicable):**
Briefly tell us your reasons for choosing our practice and how you found out about us.	**Please list the ages and names of all members in your household:**

MENSTRUAL HISTORY:

1st day of last menstrual period _____	How often do you have periods? Every _____ days
Was this a normal, regular, on-time, normal period for you? ☐Yes ☐ No _____	
Were you using any methods to prevent pregnancy? ☐No ☐Yes _____	
Did you conceive using infertility treatment? ☐No ☐Yes _____	
Date of 1st positive pregnancy test _____	Any spotting or bleeding since LMP? _____

HISTORY SINCE LMP:

Since your last menstrual period, have you been exposed to any of the following:

☐ X-Rays or exposure to hazardous chemicals or other substances _____

☐Rash or viral illnesses ☐Hospitalizations or emergency room visits _____

☐Travel outside the country? _____

☐Have you experienced any major life changes / stressors (moving, death in family, loss of job, etc) _____

_____

	Amt / Day prior to pregnancy	Amt / day now	# Years Use	Attempts to quit?	**List any medications (prescription or over-the-counter), supplements, herbal preparations since LMP.**		
Tobacco use							
Alcohol consumption							
Ilicit ("street") drugs							

PRENATAL CARE RECORD (page 2 of 3) **Name: _____**

PAST MEDICAL HISTORY					
Do you have a history of any of the following? Indicate in the column with (+) sign or (-) sign.		**Detail + remarks. Include date and treatment**	**Condition:**	**0 NEG + POS**	**Detail + remarks include date & treatment**
1. Diabetes			22. Surgeries (non-gyn)		
2. High blood pressure			23. Anesthesia complications		
3. Anemia			**GYNECOLOGICAL HISTORY**		
4. Blood disorders or blood clots			24. Breast conditions		
5. Varicose veins			25. Endometriosis		
6. Thyroid dysfunction			26. Painful or heavy periods		
7. Heart disease/ Rheumatic fever			27. Abnormal pap smears		
8. Kidney disease or frequent urinary tract infections			28. Infertility		
			29. Gynecological procedures		
9. Hepatitis or liver disease			30. Uterine or cervical abnormalities		
10. Seizure disorder/ Epilepsy			31. HPV or genital warts		
11. Asthma or pulmonary disease			32. Chlamydia or gonorrhea		
12. Tuberculosis or + PPD skin test			33. Genital Herpes		
13. Autoimmune disorders			**IMMUNIZATION HISTORY:**		
14. Digestive disorders - GERD or IBS			34. Chicken pox or vaccine		
15. Migraine headaches			35. Date of pertussis vaccine		
16. Arthritis / Chronic pain			37. Date of last tetanus shot		
17. Cancer			38. Seasonal influenza vaccine		
18. HIV			**ALLERGIES:**		
19. Major depression / Anxiety / Psychiatric disorders			**FAMILY HISTORY:**		
			1. Diabetes		
20. Major accidents / injuries / Hospitalizations			2. Heart Disease, Stroke, High blood pressure		
21. D (Rh) sensitization			3. Cancer		
22. Blood transfusion			4. Psychiatric disorders		

PLEASE LIST ALL PRIOR PREGNANCY OUTCOMES, BEGINNING WITH THE MOST RECENT:

Year	Place of birth	Birth setting – Birth Center, Home, Hospital	# Wks gestation	Length of Labor	Type of Delivery	M/F	Infant's weight	Complications of during pregnancy or birth?	Duration of breastfeeding

Comments (number and explain):

_____

_____

_____

…….. Patients stop here ……

Prenatal Care Record (page 3 of 3) **Name: _____**

PHYSICAL EXAM						
DATE: _____ **BP: _____** **HR: _____** **HT: _____** **WT. AT LMP _____** **BMI: _____**						
1. HEENT	☐NML	☐ABN	**12. LYMPH NODES**	☐NML	☐ABN	
2. FUNDI	☐NML	☐ABN	**13. EXT. GENITALIA**	☐NML	☐LESIONS	
3. TEETH	☐NML	☐ABN	**14. ANUS**	☐NML	☐HEMORRHOIDS	☐LESIONS
4. THYROID	☐NML	☐ABN	**15. VULVA**	☐NML	☐LESIONS	
5. BREASTS	☐NML	☐ABN	**16. VAGINA**	☐NML	☐INFLAMMATION	☐DISCHARGE
6. LUNGS	☐NML	☐ABN		WET PREP / KOH		
7. HEART	☐NML	☐ABN	**17. CERVIX**	☐NML	☐INFLAMMATION	☐DISCHARG
8. ABDOMEN	☐NML	☐ABN	**18. UTERUS**	SIZE _____ WKS	POSITION _____	☐TENDER
9. EXTREMITIES	☐NML	☐ABN	**19. ADNEXAE**	☐NML	☐MASS	☐TENDER
10. SKIN	☐NML	☐ABN	**2O. RECTUM**	☐DEFERRED	☐NML	☐ABN
11. TATTOOS			**21. PELVIS**	☐ADEQUATE	☐PROVEN	☐ABN
COMMENTS:						
Signature / Date						

☐**ROS / Health history reviewed:** _____

☐**Genetic screening assessment reviewed:** _____

☐**Nutritional Assessment / Diet Hx reviewed:** _____

☐**Edinburgh Depression Screening tool reviewed:** Score _____ ☐ _____

☐**Pregnancy support assessment reviewed:** _____

PREGNANCY ASSESSMENT:

1. _____
   _____
2. _____
   _____
3. _____
   _____
4. _____
   _____

PREGNANCY / BIRTH PLANS:

☐Normal pregnancy guideline ☐Planned TOLAC and VBAC

☐New OB prenatal panel ☐HbsAg ☐HIV screen ☐CF scrn

☐US dates / viability ☐NT screen

☐Pap w/Reflex HPV ☐HPV DNA ☐GC/CT screen

☐MFM consult / genetic counseling _____

☐Nutritional counseling referral _____

☐Medical records release _____

☐Prenatal vitamins Rx given ☐Taking OTC vitamins

☐ Other: _____

☐ Education and Counseling performed - see teaching check list ☐Return to clinic _____ ☐days ☐weeks

_____

CNM signature / date