Prenatal Record Keeping System

Date _____ Name _____
Last First Middle

ID# _____ Hospital of Delivery _____

Newborn's Physician _____ Referred by _____

Final EDD _____

Birthdate _____ Age _____ Race ❑ W ❑ B ❑ O Marital Status ❑ S ❑ M ❑ W ❑ D ❑ Sep
Month/Day/Year

Address _____ Phone _____
City State Zip Code Home Work

Occupation _____ Education _____ Medicaid#/Insurance/Pre-Cert _____
(Last Grade Completed)

Emergency Contact _____ Relationship _____ Phone _____
Home Work

Father of Baby _____ Age ____ Occupation _____ Health Status _____ Phone _____
Home Work

Previous Obstetrical History

Date Mo/Yr	GA Weeks	Length of Labor	Birth Weight	Type Delivery	Anes.	Place of Delivery	Perinatal Mortality Yes/No	Treatment Preterm Labor Yes/No	Sex	Remarks

Total Preg.	Full Term	Premature	Abortions Induced	Abortions Spontaneous	Ectopics	Multiple Births	Living

Previous Medical History

	+/-	Remarks		+/-	Remarks
Diabetes			Tobacco/Alcohol		
Hypertension			Recreational Drugs		
Heart Disease			STD		
Rheumatic Fever			Tuberculosis		
Mitral Valve Prolapse			Asthma		
Kidney Disease/UTI			Allergies (Drugs)		
Nervous/Mental			GYN Surgery		
Epilepsy			Operations/Hospitalizations (Year & Reason)		
Hepatitis/Liver Disease					
Varicosities/Phlebitis			History of Abnormal Pap		
Thyroid Dysfunction			Uterine Anomaly		
Major Accidents			Infertility		
Anesthesia Complications			In Utero DES Exposure		
History of Blood Transfusion			Other		

Health Care Provider(s) Identification

Printed Name _____ Initials _____ Signature _____

Printed Name _____ Initials _____ Signature _____

Printed Name _____ Initials _____ Signature _____

Printed Name _____ Initials _____ Signature _____