Patient Name/I.D. Number ____________________

Physician Name ____________________

Confirmation of EDD

Initial EDD

- LMP ___/___/___ =EDD___/___/___
- Initial Exam ___/___/___ =___Wks. =EDD___/___/___
- Ultrasound ___/___/___ =___Wks. =EDD___/___/___
- Initial EDD ___/___/___ Initialed By__________

LMP ❒ Definite
❒ Normal Amount/Duration
❒ Approximate (Month Known)
❒ Unknown

Menarche__________(Age Onset)
Menses Monthly ❒ Yes ❒ No
Frequency Q_______Days
Prior Menses_______Date
On BCP's at Conception ❒ Yes ❒ No

HCG - ___/___/___ (if indicated)
HCG + ___/___/___ (if indicated)

Drug Allergies	Blood Type

Problems/Plans (current pregnancy)

1
2.
3.
4.
5.
6.

Medications/Present/Pre-Conception	Start	Stop
1.		
2.		
3.		
4.		
5.		
6.		

Visit Flow Sheet

LMP ____________________ Final EDD ____________________

Visit Date	Gestational Age		Weight	BP	Pos.	Fetal Activ.	FHT	Urine		Edema	Cervical Exam	Notes	Return Visit	(Initial)
	Weeks	Fnd Ht						Protein	Sugar					