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					