



DELAWARE PREGNANCY RECORD - PAGE 1

Date of birth _____ Place _____ Age _____
 Race _____ Education (yrs) _____ Religion _____
 Occupation _____
 Employer _____ Phone # _____
 Marital status _____ Maiden name _____
 Baby's Dr _____
 INS 1: _____ INS 2: _____
 Referring Physician: _____

Patient's name, address and home phone # must appear above.

Partner's name _____ Age _____	Allergies _____ <input type="checkbox"/> NKDA
Date of birth _____ Place _____ Race _____	LMP _____ EDC _____ Corrected _____
Address _____ ZIP _____	Transfusion Hx _____ EDC _____
Home phone _____ Work phone _____	Medications _____
Occupation _____ Employer _____	Prenatal class: <input type="checkbox"/> yes <input type="checkbox"/> no Father in DR: <input type="checkbox"/> yes <input type="checkbox"/> no
Education _____ Religion _____ Marital status _____	Breast feeding: <input type="checkbox"/> yes <input type="checkbox"/> no Circumcision: <input type="checkbox"/> yes <input type="checkbox"/> no

TOTAL	FULL TERM	PREMATURE	ABORTIONS INDUCED	ABORTIONS SPONTANEOUS	ECTOPICS	MULTIPLE BIRTHS	LIVING
-------	-----------	-----------	-------------------	-----------------------	----------	-----------------	--------

PAST PREGNANCIES (LAST SIX (6))

DATE (mo/yr)	G.A. (wks)	LENGTH OF LABOR	BIRTH Wt	TYPE DELIVERY	anes	PLACE OF DELIVERY	PERINATAL MORTALITY	TREATMENT PRETERM LABOR	COMMENTS/COMPLICATIONS
							<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	
							<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	
							<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	
							<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	
							<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	

PAST MEDICAL HISTORY

o NEG + POS	Patient Hx	Family Hx	Patient Hx	Family Hx
Diabetes			Rh sensitized	
Hypertension			Asthma	
Heart disease			Operations / hospitalizations (year and reason)	
Rheumatic fever			GYN surgery	
Mitral valve prolapse			anes complications	
Kidney disease / UTI			Hx abnormal PAP	
Nervous / Mental			Uterine anomaly	
Epilepsy			Infertility	
Hepatitis / liver dz			In utero DES exposure	
Varicosities / phlebitis			Street drugs	
Thyroid dysfunction			Other:	
Major accidents				
Other:				

USE OF TOBACCO <input type="checkbox"/> yes <input type="checkbox"/> no	# cigs/day prior to PREG _____ # cigs/day now _____ Age onset smoking _____	USE OF ALCOHOL: <input type="checkbox"/> yes <input type="checkbox"/> no	# drinks/wk prior to PREG _____ # drinks/wk now _____ Age onset drinking _____
---	---	--	--

INFECTION SCREENING	YES	NO	INFECTION SCREENING	YES	NO
High risk HIV exposure?			Genital herpes (patient or partner)?		
High risk Hepatitis B?			STD. GC, chlamydia, HPV, syphilis?		
Live with someone with TB or exposed to TB?					

Completed by: _____

Signature/Title _____ Print Name _____ Date _____
 19331-1 S (15255)(1097)C