CHRISTIANA CARE
HEALTH SERVICES

DELAWARE PREGNANCY RECORD - PAGE 2

GENETICS SCREENING

INCLUDES PATIENT, BABY'S FATHER, OR ANYONE IN EITHER FAMILY

	YES	NO
1. PATIENT'S AGE > 35 YEARS AT DELIVERY?		
2. ITALIAN, GREEK, MEDITERRANEAN, OR ORIENTAL BACKGROUND (MCV < 80)?		
3. NEURAL TUBE DEFECT (MENINGOMYELOCELE, OPEN SPINE, OR ANENCEPHALY)?		
4. DOWN'S SYNDROME (MONGOLISM)?		
5. JEWISH (TAY SACH'S)?		
6. SICKLE CELL DISEASE OR TRAIT?		
7. HEMOPHILIA?		
8. MUSCULAR DYSTROPHY?		
9. CYSTIC FIBROSIS?		
10. HUNTINGTON CHOREA?		
11. MENTAL RETARDATION?		
IF YES, WAS PERSON TESTED FOR FRAGILE X?		
12. OTHER INHERITED GENETIC OR CHROMOSOMAL DISORDERS.		
13. PATIENT OR BABY'S FATHER HAD A CHILD WITH BIRTH DEFECT NOT LISTED ABOVE, 3 FIRST TRIMESTER SPONTANEOUS ABORTIONS OR STILLBIRTH?		
14. MEDICATIONS OR STREET DRUGS SINCE LAST MENSTRUAL PERIOD?		
15. CONSANGUINITY		
16. INFANT DEATH		

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

COMMENTS

SIGNATURE/TITLE PRINT NAME

INITIAL PHYSICAL EXAMINATION

DATE ____ / ____ / ____ PRE-PREGNANCY WEIGHT ____ HEIGHT ____ BP ____

1. HEENT	☐ NORMAL	☐ ABNORMAL	13. RECTUM	☐ NORMAL	☐ ABNORMAL		
2. FUNDI	☐ NORMAL	☐ ABNORMAL	14. VULVA	☐ NORMAL	☐ CONDYLOMA	☐ LESIONS	
3. TEETH/DENTITION	☐ NORMAL	☐ ABNORMAL	15. VAGINA	☐ NORMAL	☐ INFLAMMATION	☐ DISCHARGE	
4. THYROID	☐ NORMAL	☐ ABNORMAL	16. CERVIX	☐ NORMAL	☐ INFLAMMATION	☐ LESIONS	
5. BREASTS	☐ NORMAL	☐ ABNORMAL	17. UTERUS	☐ NORMAL	☐ ABNORMAL ____	FIBROIDS ____	WEEKS
6. LUNGS	☐ NORMAL	☐ ABNORMAL	18. ADNEXA	☐ NORMAL	☐ MASS		
7. HEART	☐ NORMAL	☐ ABNORMAL	19. DIAGONAL CONJUGATE	☐ NORMAL	☐ NO	____	cm
8. ABDOMEN	☐ NORMAL	☐ ABNORMAL	20. SPINES	☐ NORMAL	☐ PROMINENT	☐ BLUNT	
9. EXTREMITIES	☐ NORMAL	☐ ABNORMAL	21. SACRUM	☐ NORMAL	☐ STRAIGHT	☐ ANTERIOR	
10. SKIN	☐ NORMAL	☐ ABNORMAL	22. ARCH	☐ NORMAL	☐ WIDE	☐ NARROW	
11. LYMPH NODES	☐ NORMAL	☐ ABNORMAL	23. PELVIC TYPE	GYNECOID	☐ YES ☐ NO		
12. NEUROLOGICAL	☐ NORMAL	☐ ABNORMAL	24. OTHER				

COMMENTS (Number and explain abnormals)

EXAM BY: SIGNATURE/TITLE PRINT NAME DATE

PLANS/EDUCATION

	COUNSELED INITIALS	DATE
TOXOPLASMOSIS		
CHILDBIRTH CLASSES		
PHYSICAL ACTIVITY		
PREMATURE LABOR SIGNS		
NUTRITION COUNSELING		
METHOD OF ANESTHESIA		
BREAST OR BOTTLE FEEDING		
NEWBORN CAR SEAT		
POSTPARTUM BIRTH CONTROL		
ENVIRONMENTAL/WORK HAZARDS		

	COUNSELED INITIALS	DATE
TUBAL STERILIZATION		
VBAC COUNSELING		
CIRCUMCISION		
TRAVEL		
REQUESTS		
OTHER		

TUBAL STERILIZATION DATE INITIALS

CONSENT SIGNED ____ / ____ / ____ ____

INIT.	Signature/Title	Print Name	INIT.	Signature/Title	Print Name