DATE ____________________
NAME ____________________

Pacific Obstetrics & Gynecology

CHRISTINA J. LEE, MD • JENNIFER C. LEE, MD

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Phone: 949-548-6800 • Fax: 949-548-6801

ID# ____________ HOSPITAL OF DELIVERY ____________

NEWBORN'S PHYSICIAN ____________ REFERRED BY ____________

FINAL EDD ____________ PRIMARY PROVIDER/GROUP ____________

BIRTH DATE MONTH DAY YEAR	AGE	RACE	MARITAL STATUS S M W D SEP	ADDRESS			
OCCUPATION		EDUCATION (LAST GRADE COMPLETED)		ZIP	PHONE	(H)	(O)
LANGUAGE				INSURANCE CARRIER / MEDICAID #			
HUSBAND / DOMESTIC PARTNER		PHONE		POLICY #			
FATHER OF BABY		PHONE		EMERGENCY CONTACT		PHONE	
TOTAL PREG	FULL TERM	PREMATURE	AB. INDUCED	AB. SPONTANEOUS	ECTOPICS	MULTIPLE BIRTHS	LIVING

MENSTRUAL HISTORY

LMP ☐ DEFINITE ☐ APPROXIMATE (MONTH KNOWN) MENSES MONTHLY ☐ YES ☐ NO FREQUENCY: Q________ DAYS MENARCHE ____________ (AGE ONSET)

☐ UNKNOWN ☐ NORMAL AMOUNT / DURATION PRIOR MENSES ________ DATE ON BCP AT CONCEPT ☐ YES ☐ NO hCG + _____/_____/_____

☐ FINAL

PAST PREGNANCIES (LAST SIX)

DATE MONTH/ YEAR	GA WEEKS	LENGTH OF LABOR	BIRTH WEIGHT	SEX M/F	TYPE DELIVERY	ANES.	PLACE OF DELIVERY	PRETERM LABOR YES/NO	COMMENTS / COMPLICATIONS

MEDICAL HISTORY

	O NEG. + POS	DETAIL POSITIVE REMARKS INCLUDE DATE & TREATMENT			O NEG. + POS	DETAIL POSITIVE REMARKS INCLUDE DATE & TREATMENT
1. DIABETES				17. D (Rh) SENSITIZED		
2. HYPERTENSION				18. PULMONARY (TB, ASTHMA)		
3. HEART DISEASE				19. SEASONAL ALLERGIES		
4. AUTOIMMUNE DISORDER				20. DRUG / LATEX ALLERGIES / REACTIONS		
5. KIDNEY DISEASE / UTI						
6. NEUROLOGIC / EPILEPSY				21. BREAST		
7. PSYCHIATRIC				22. GYN SURGERY		
8. DEPRESSION POSTPARTUM DEPRESSION						
9. HEPATITIS / LIVER DISEASE				23. OPERATIONS / HOSPITALIZATIONS (YEAR & REASON)		
10. VARICOSITIES / PHLEBITIS						
11. THYROID DYSFUNCTION				24. ANESTHETIC COMPLICATIONS		
12. TRAUMA / VIOLENCE				25. HISTORY OF ABNORMAL PAP		
13. HISTORY OF BLOOD TRANSFUS				26. UTERINE ANOMALY/DES		
	AMT DAY PREPREG	AMT DAY PREG	# YEARS USE	27. INFERTILITY		
14. TOBACCO				28. RELEVANT FAMILY HISTORY		
15. ALCOHOL						
16. ILLICIT / RECREATIONAL DRUGS				29. OTHER		

COMMENTS ____________________

ACOG ANTEPARTUM RECORD (FORM A)

SYMPTOMS SINCE LMP

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GENETIC SCREENING / TERATOLOGY COUNSELING

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

	YES	NO		YES	NO
1. PATIENT'S AGE ≥ 35 YEARS AS OF ESTIMATED DATE OF DELIVERY			12. HUNTINGTON'S CHOREA		
2. THALASSEMIA (ITALIAN, GREEK, MEDITERRANEAN OR ASIAN BACKGROUND); MCV <80			13. MENTAL RETARDATION / AUTISM		
3. NEURAL TUBE DEFECT (MENINGOMYELOCELE, SPINA BIFIDA, OR ANENCEPHALY)			IF YES, WAS PERSON TESTED FOR FRAGILE X?		
4. CONGENITAL HEART DEFECT			14. OTHER INHERITED GENETIC OR CHROMOSOMAL DISORDER		
5. DOWN SYNDROME			15. MATERNAL METABOLIC DISORDER (EG. TYPE 1 DIABETES, PKU)		
6. TAY-SACHS (EG. JEWISH, CAJUN, FRENCH CANADIAN)			16. PATIENT OR BABY'S FATHER HAD A CHILD WITH BIRTH DEFECTS NOT LISTED ABOVE		
7. CANAVAN DISEASE			17. RECURRENT PREGNANCY LOSS, OR A STILLBIRTH		
8. SICKLE CELL DISEASE OR TRAIT (AFRICAN)			18. MEDICATIONS (INCLUDING SUPPLEMENTS, VITAMINS, HERBS OR OTC DRUGS / ILLICIT / RECREATIONAL DRUGS / ALCOHOL SINCE LAST MENSTRUAL PERIOD		
9. HEMOPHILIA OR OTHER BLOOD DISORDERS					
10. MUSCULAR DYSTROPHY			IF YES, AGENT(S) AND STRENGTH / DOSAGE.		
11. CYSTIC FIBROSIS			19. ANY OTHER		

COMMENTS/COUNSELING____

INFECTION HISTORY	YES	NO		YES	NO
1. LIVE WITH SOMEONE WITH TB OR EXPOSED TO TB			4. HISTORY OF STD, GONORRHEA, CHLAMYDIA, HPV, SYPHILIS		
2. PATIENT OR PARTNER HAS HISTORY OF GENITAL HERPES					
3. RASH OR VIRAL ILLNESS SINCE LAST MENSTRUAL PERIOD			5. OTHER (See Comments)		

COMMENTS ____

___________________________ INTERVIEWER'S SIGNATURE ___________________

INITIAL PHYSICAL EXAMINATION

DATE ______ / ______ / ______ HEIGHT __________ BP __________

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

COMMENTS (Number and explain abnormals) ___________________________________

___________________________ EXAM BY ___________________

ACOG ANTEPARTUM RECORD (FORM B)