

**NAVAL HOSPITAL ROTA  
ANTEPARTUM RECORD – PART 1**

**NAME:** \_\_\_\_\_

**SSN:** \_\_\_\_\_

BIRTH DATE _____ MO / DAY / YR	AGE _____	RACE _____	MARITAL STATUS  S M W D SEP	OCCUPATION: <input type="checkbox"/> WORK <input type="checkbox"/> HOMEMAKER <input type="checkbox"/> STUDENT	HIGHEST LEVEL OF EDUCATION:  TYPE OF WORK: _____	PRIMARY LANGUAGE:  PATIENT'S SOCIAL SECURITY # _____
CATEGORY : <input type="checkbox"/> AD/Rank _____ <input type="checkbox"/> DEP AD _____ <input type="checkbox"/> RET _____ <input type="checkbox"/> DEP RET _____	<input type="checkbox"/> NAVY <input type="checkbox"/> ARMY <input type="checkbox"/> AIR FORCE <input type="checkbox"/> MARINES <input type="checkbox"/> DOD	ADDRESS:  City _____ State _____ Zip _____  (Home) _____  (Work) _____ (Cell) _____	Husband/FOB _____ (name) _____ (phone) _____  Emergency Contact _____ (name) _____ (phone) _____			

**PAST PREGNANCIES**

DATE MO / YR	GA WEEKS	LENGTH OF LABOR	SEX M / F	BIRTH WEIGHT	TYPE OF DELIVERY	ANEST	PLACE OF DELIVERY	PRETERM LABOR YES / NO	COMMENTS / COMPLICATIONS

**PAST MEDICAL HISTORY**

	O=Neg +=Pos	DETAIL POSITIVE REMARKS INCLUDE DATE & PLACE OF TREATMENT	O=Neg +=Pos	DETAIL POSITIVE REMARKS INCLUDE DATE & PLACE OF TREATMENT		
1. DIABETES				15. ALLERGIES (DRUGS OR LATEX) REACTIONS		
2. HYPERTENSION			16. D (RH) SENSITIZED			
3. HEART DISEASE			17. OPERATIONS/HOSPITALIZATIONS (YEAR & REASON)			
4. MITRAL VALVE PROLAPSE			18. ANESTHETIC COMPLICATIONS			
5. AUTOIMMUNE DISORDER			19. HISTORY OF ABNORMAL PAP			
6. KIDNEY DISEASE / UTI / STONES			20. UTERINE ANOMALY/DES			
7. NEUROLOGIC / EPILEPSY / MIGRAINE			21. INFERTILITY			
8. PSYCHIATRIC ILLNESS, DEPRESSION, POSTPARTUM DEPRESSION			22. BREAST/GYN SURGERY			
9. HEPATITIS / LIVER / GI DISEASE			24. SKIN DISORDERS/TATTOS/PIERCINGS			
10. VARICOSITIES / PHLEBITIS			<b>HABITS</b>			
11. THYROID DYSFUNCTION				AMT / DAY PREPREG	AMT / DAY PREG	# YRS USE
12. HX OF TRAUMA, VIOLENCE or DOMESTIC ABUSE? Within the last year, have you been hit, slapped, kicked, physically hurt or forced to have sex?			25. TOBACCO			
13. HIST. OF BLOOD TRANSFUSION			26. ALCOHOL			
14. PULMONARY (TB/ASTHMA)			27. ILLICIT/RECREATIONAL DRUGS			
		<b>FAMILY HISTORY</b>		O=Neg +=Pos		

**INFECTION HISTORY**

	O=Neg +=Pos		COMMENTS:
28. HX OF CHICKEN POX, RUBELLA, MUMPS		36. HYPERTENSION	
29. LIVE WITH SOMEONE WITH TB OR EXPOSED TO TB		37. HEART DISEASE	
30. PATIENT OR PARTNER HAS HISTORY OF GENITAL HERPES		38. DIABETES	
31. RASH OR VIRAL ILLNESS SINCE LAST MENSTRUAL PERIOD		39. EPILEPSY	
32. HISTORY OF STD (GC, CHLAMYDIA, SYPHILIS, HPV)		40. ASTHMA	
33. HIGH RISK OF HEPATITIS B OR IMMUNIZED		41. MULTIPLE BIRTH	
34. DO YOU HAVE A CAT?		42. OTHER	
35. WHEN WAS YOUR LAST TETANUS VACCINE?			

**NAVAL HOSPITAL ROTA SPAIN  
ANTEPARTUM RECORD - PART 2**

<b>GENETICS SCREENING - Includes baby's father or anyone in either family with:</b>				YES	NO
		YES	NO	YES	NO
1. PATIENT'S AGE >34 YEARS AS OF DUE DATE					
2. THALASSEMIA (ITALIAN, GREEK, MEDITERRANEAN, OR ORIENTAL BACKGROUND): MCV < 80					
3. NEURAL TUBE DEFECT (MENINGOMYELOCELE, SPINA BIFIDA OR ANENCEPHALY)					
4. DOWN SYNDROME					
5. TAY-SACHS (EG, JEWISH, CAJUN, FRENCH CANADIAN)					
6. HEMOPHILIA OR OTHER BLOOD DISORDERS					
7. SICKLE CELL DISEASE OR TRAIT					
8. CONGENITAL HEART DEFECT					
9. MUSCULAR DYSTROPHY					
10. CYSTIC FIBROSIS					
				11. HUNTINGTON'S CHOREA	
				12. MENTAL RETARDATION/AUTISM	
				(IF YES, WAS PERSON TESTED FOR FRAGILE X?)	
				13. OTHER INHERITED GENETIC OR CHROMOSOMAL DISORDER	
				14. PATIENT OR BABY'S FATHER HAD A CHILD WITH BIRTH DEFECTS NOT LISTED ABOVE	
				15. RECURRENT PREGNANCY LOSS OR STILLBIRTH	
				16. MEDICATIONS OR STREET DRUGS SINCE LAST MENSTRUAL PERIOD (IF YES, AGENTS)	
				17. CANAVAN DISEASE	
				18. MATERNAL METABOLIC DISORDER (EG, TYPE 1 DIABETES, PKU)	
				19. OTHER SIGNIFICANT FAMILY HISTORY (SEE COMMENTS)	

**COMMENTS**

**INTERVIEWER'S SIGNATURE:**

**INITIAL PHYSICAL EXAMINATION**

**DATE:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **PREPREGNANCY WEIGHT** \_\_\_\_\_ **HEIGHT** \_\_\_\_\_ **BP** \_\_\_\_\_

				COMMENTS: (Number and explain abnormal)
1. HEENT/TEETH	<input type="checkbox"/> NORMAL	<input type="checkbox"/> ABNORMAL	<input type="checkbox"/> NOT EXAMINED	
2. THYROID	<input type="checkbox"/> NORMAL	<input type="checkbox"/> ABNORMAL		
3. BREAST	<input type="checkbox"/> NORMAL	<input type="checkbox"/> ABNORMAL		
4. LUNGS	<input type="checkbox"/> NORMAL	<input type="checkbox"/> ABNORMAL		
5. HEART	<input type="checkbox"/> NORMAL	<input type="checkbox"/> ABNORMAL		
6. ABDOMEN	<input type="checkbox"/> NORMAL	<input type="checkbox"/> ABNORMAL		
7. EXTREMITIES	<input type="checkbox"/> NORMAL	<input type="checkbox"/> ABNORMAL		
8. SKIN	<input type="checkbox"/> NORMAL	<input type="checkbox"/> ABNORMAL		
9. LYMPH NODES	<input type="checkbox"/> NORMAL	<input type="checkbox"/> ABNORMAL		
10. VULVA	<input type="checkbox"/> NORMAL	<input type="checkbox"/> CONDYLOMA	<input type="checkbox"/> LESIONS	
11. VAGINA	<input type="checkbox"/> NORMAL	<input type="checkbox"/> INFLAMMATION	<input type="checkbox"/> DISCHARGE	
12. CERVIX	<input type="checkbox"/> NORMAL	<input type="checkbox"/> INFLAMMATION	<input type="checkbox"/> LESIONS	
13. UTERUS SIZE: ____ WKS	<input type="checkbox"/> NORMAL	<input type="checkbox"/> ABNORMAL	<input type="checkbox"/> FIBROIDS	
14. ADNEXA	<input type="checkbox"/> NORMAL	<input type="checkbox"/> MASS	<input type="checkbox"/> TENDER	
15. RECTUM	<input type="checkbox"/> NORMAL	<input type="checkbox"/> MASS	<input type="checkbox"/> NOT EXAMINED	
16. DIAGONAL CONJUGATE	<input type="checkbox"/> NOT REACHED	<input type="checkbox"/> REACHED	_____ CM	
17. SPINES	<input type="checkbox"/> AVERAGE	<input type="checkbox"/> PROMINENT	<input type="checkbox"/> BLUNT	
18. SACRUM	<input type="checkbox"/> CONCAVE	<input type="checkbox"/> STRAIGHT	<input type="checkbox"/> ANTERIOR	
19. ARCH	<input type="checkbox"/> NORMAL	<input type="checkbox"/> WIDE	<input type="checkbox"/> NARROW	
20. GYNECOID PELVIC TYPE	<input type="checkbox"/> YES	<input type="checkbox"/> NO		

**COMMENTS:**

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**EXAMINERS'S SIGNATURE** \_\_\_\_\_