# MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see requiring document. Form is not valid without Requiring Document, Issuance Date, Local Form Number, and Edition Date.

| REQUIRING DOCUMENT *(Title and Number)* | ISSUANCE DATE |
|---|---|
| NAVHOSPBREMNOTE 5213 | 14 Apr 2015 |

LOCAL FORM TITLE *(Optional)*
NAVAL HOSPITAL BREMERTON ANTEPARTUM RECORD

BMI (pre-preg): _____ Expected weight gain: _____ EPDS Score: Initial: _____ 32 WKS: _____

## PROBLEM LIST AND PLAN

1.

## PAST OBSTETRICAL HISTORY

☐ NONE

| Date Mo/Yr | EGA wks | Length of Labor (hrs) | Birth Weight | Sex | Type of Delivery | Anesthesia | Location | Comments / Complications (GDM, HTN, Shoulder dystocia) |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

| PMH: | PSH: | GYN: | FHx: | Medications: | Allergies: |
|---|---|---|---|---|---|
| | | | Social: | | |

| Date | Labs | Result |
|---|---|---|
| | Blood Type | A B O AB |
| | Rh | + / -- |
| | Antibody | + / -- |
| | Rubella | IMMUNE / NI |
| | RPR | NEG / POS |
| | HbSAg | NEG / POS |
| | HIV | NEG / POS |
| | Urine Culture | |
| | Pap | |
| | GC/Chlamydia | |
| | Early 1h screen | |
| | CBC | >----------< |
| | Varicella | ☐ + History<br>☐ IgG: |

| Date | Labs | Result |
|---|---|---|
| | Genetic Screening | ☐ Declines ☐ Elects _____ |
| | Cystic Fibrosis | |
| | Hgb Electrophoresis | |
| | 1 Hr GTT / 3 Hr GTT | _____ / F: 1: 2: 3: |
| | CBC | >----------< |
| | GBS | ☐ + / - Exp:<br>☐ + / - Exp: |

Other

| PRACTITIONER'S NAME | PRACTITIONER'S SIGNATURE | DATE |
|---|---|---|
| PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)* | HOSPITAL OR MEDICAL FACILITY | STATUS |
| | DEPARTMENT / SERVICE | RECORDS MAINTAINED AT |
| | SPONSOR'S NAME | SSN |
| | RELATIONSHIP TO SPONSOR | |

| Age | Gravida | Full Term | Preterm | Abortions/Ectopics | Living |
|---|---|---|---|---|---|
| | | | | | |

REVIEW OF DATES AND ULTRASOUNDS

LMP _____ ☐ Sure ☐ Approx ☐ Unk EDC By LMP _____

FINAL EDD ☐ LMP ☐ U/S

| | Date | EGA | EGA by this Ultrasound | EDC by this Ultrasound | EFW / % | Placenta: _____ Os clear: ☐ Yes ☐ No |
|---|---|---|---|---|---|---|
| 1st | | | | | g ( %) | |
| 2nd | | | | | g ( %) | |
| 3rd | | | | | g ( %) | |
| 4th | | | | | g ( %) | |

**PRENATAL VISITS** Ht: _____ Pre-Pregnancy Weight: _____

| Visit Dates | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| EGA (wks) | | | | | | | | | | | | | | |
| BP | | | | | | | | | | | | | | |
| Maternal HR | | | | | | | | | | | | | | |
| Pain Score | | | | | | | | | | | | | | |
| Wght/TWG | | | | | | | | | | | | | | |
| FM | | | | | | | | | | | | | | |
| Contractions | | | | | | | | | | | | | | |
| FH | | | | | | | | | | | | | | |
| Fetal HR | | | | | | | | | | | | | | |
| Presentation | | | | | | | | | | | | | | |
| Cervix | | | | | | | | | | | | | | |
| Comments | | | | | | | | | | | | | | |
| Type/ Next Appt | | | | | | | | | | | | | | |
| Provider | | | | | | | | | | | | | | |

**PHONE NUMBER:**

**EMAIL:**

| DATE | VACCINES | INITIALS |
|---|---|---|
| | Influenza | |
| | TDaP | |
| | RhoGAM | |
| | | |

| | |
|---|---|
| Feeding Plan: | **Breast / Bottle** |
| Postpartum Contraception: | |
| Birth Plan: | ☐ Birth Classes<br>Newborn: Vit K Erythro Circ |
| Delivery Plan/Date: | |
| Hemorrhage Risk: | Low Mod High |

| PRACTITIONER'S NAME | PRACTITIONER'S SIGNATURE | DATE |
|---|---|---|
| PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)* | HOSPITAL OR MEDICAL FACILITY | STATUS |
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| | RELATIONSHIP TO SPONSOR | |