

PATIENT HISTORY (Check Yes or No)

Y		N		Y		N		Y		N		Y		N					
(1) DIABETES				(2) HYPERTENSION				(3) HEART DISEASE				(4) AUTOIMMUNE				(5) KIDNEY DISEASE			
(6) UTI				(7) PSYCHIATRIC D/O				(8) NEURO/SEIZURE D/O				(9) HEPATITIS				(10) LIVER DISEASE			
(11) VARICOSITIES/PHLEB				(12) THYROID DYSFUNC				(13) RH SENSITIZED				(14) ASTHMA				(15) BREAST PROBLEMS			
(16) ABNORMAL PAP				(17) UTERINE ABNOR				(18) INFERTILITY				(19) SURG HX				(20) RELEVANT FAM HX			
(21) ANESTHESIA COMP				(22) DOMESTIC ABUSE				(23) TB				(24) PULM DISEASE				(25) OTHER			

REMARKS:

PAST PREGNANCIES

DATE	WEEKS GEST	LENGTH LABOR	TYPE DELIVERY	ANES / ANAL	HOSPITAL LOCATION	SEX	WEIGHT	COMPLICATIONS / REMARKS

INFECTION HISTORY (Check Yes or No)

Y		N		Y		N	
HIGH RISK FOR HEPATITIS				HX OF STD: GC, CHLAMYDIA, SYPHILIS, HPV			
EXPOSED TO TB				HX OF CHICKEN POX			
PATIENT OR PARTNER WITH HX OF GENITAL HERPES				OTHER INFECTION (SPECIFY): _____			
RASH OR VIRAL ILLNESS SINCE LMP							

GENETIC RISK SCREENING (Includes patient, baby's father, or anyone in either family.)

Y		N		REMARKS	Y		N		REMARKS
THALASSEMIA (HIGHER RISK IN PTS WITH ITALIAN/GREEK/MEDITERRANEAN OR ASIAN BACKGROUND)									RECURRENT PREGNANCY LOSS OR STILLBORN. IF YES, WHAT WORK UP HAS BEEN DONE?
NEURAL TUBE DEFECT (MENINGOMYELOCELE, SPINA BIFIDA, ANENCEPHALY)									SICKLE CELL DISEASE AND TRAIT (HIGHER RISK IN PTS WITH AFRICAN BACKGROUND)
TAY-SACHS (HIGHER RISK IN PTS WITH JEWISH, CAJUN, FRENCH CANADIAN BACKGROUND)									MATERNAL METABOLIC DISORDER (e.g., TYPE 1 DM, PKU, ETC.)
OTHER BIRTH DEFECTS									MUSCULAR DYSTROPHY
PATIENT'S AGE > 34 AT DELIVERY									MENTAL RETARDATION / AUTISM
DOWN SYNDROME									CYSTIC FIBROSIS
CONGENITAL HEART DISORDER									OTHER INHERITED GENETIC OR CHROMOSOMAL DISORDER / RISKS
HEMOPHILIA									

PHYSICAL EXAMINATION Normal or None Abnormal

(1) GENERAL	(2) HEAD & NECK	(3) EYES	(4) EARS	(5) NOSE
(6) MOUTH	(7) THROAT	(8) TEETH	(9) CHEST	(10) BREASTS
(11) NIPPLES	(12) LUNGS	(13) HEART	(14) ABDOMEN	(15) HERNIA
(16) BACK	(17) EXTREMITIES	(18) NEUROLOGIC	(19) SKIN	(20) LYMPHATIC

EXT. GENITALIA VAGINA
 CERVIX UTERUS
 ADNEXA RECTAL

ASSESSMENT / PLAN:

Provider's Signature: _____ Date: _____

MEDICAL RECORD - ANTEPARTUM MASTER PROBLEM LIST

For use of this form see MEDCOM Circular 40-16

This form will be completed by the health care provider

SECTION I: PROBLEM LIST

Problem	Intervention / Date	Outcome

SECTION II: ALERT LIST

Y N

SECTION III: RELATIVE CONTRAINDICATIONS TO UCP CPG

Y N

Abnormality detected on physical exam			Age (<16 or >40 years at delivery)		
Social Work needs			Past complicated pregnancy		
Single parent/dependent daughter			Prior preterm delivery (<37 weeks)		
History/current depression			Prior or current preterm labor requiring admission (e.g., early cervical change)		
Desires BTL					
Counseling performed			Intrauterine fetal demise (IUFD) or loss after 14 weeks		
VBAC					
Counseling performed			Prior cervical / uterine surgery		
Op report in chart					
Rh negative Rhogam given (Date: _____)			Fetal anatomic abnormality (e.g., neural tube defects in child or first degree relative)		
Influenza vaccine indicated Vaccine given (Date: _____)					
Last Td > 10 years Vaccine given (Date: _____)			Abnormal amniotic fluid		
			Second or third trimester bleeding		
No history of varicella			Relative BMI < 16.5		
			Hematologic disorders		

SECTION IV: ABSOLUTE CONTRAINDICATIONS TO UCP CPG

Y N

Abnormal screen (antibody, hepatitis, syphilis, or Pap)

Pre-existing diabetes			Seizure disorder		
Gestational diabetes mellitus (GDM)			Recurrent urinary tract infection/stones		
Fetal anomaly or abnormal presentation (>36 wks)			Alcohol use		
Multiple gestation			Tobacco use		
Placenta previa			Cessation offered		
Chronic hypertension			Abstinence achieved		
Systemic disease that requires ongoing care (e.g., severe asthma, lupus, and inflammatory bowel disease)			Eating disorder		
			Surgery during this pregnancy		
Drug abuse			Abnormal maternal serum analyte screen		
HIV (or abnormal screen)			Current mental illness requiring medical therapy		

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)

MEDICAL RECORD - ANTEPARTUM PATIENT QUESTIONNAIRE

For use of this form, see MEDCOM Circular 40-16

Date of First Visit: _____

Self-Administered Questionnaire - To Be Completed by Patient at First Visit

SECTION I - Medical History

	*Yes	No	Unk
1. Do you currently have or have you ever had any of the following:			
a. Ulcer, stomach problems, or colitis?			
b. Abnormal Pap smear or female/gynecological problems?			
c. Heart disease?			
d. Rheumatic disease?			
e. High blood pressure?			
f. Pneumonia or asthma?			
g. Epilepsy or seizures?			
h. Emotional problems?			
i. Thyroid problems?			
j. Diabetes, including gestational diabetes?			
k. Blood clots in your legs or elsewhere?			
l. Broken bones or other severe trauma?			
m. Lupus or other autoimmune disease?			
2. Have you had infertility problems?			
3. Are you currently in need of or have you ever had an operation?			
4. Have you ever had a blood transfusion?			
5. Are you allergic to anything?			

SECTION II - Immediate Concerns

	*Yes	No	Unk
6. Are you having pain? Scale 0-10 Location: _____ Intensity: _____ (0 = no pain - 10 = worst pain)			
7. Do you have a history of ectopic pregnancy?			
8. Do you have a history of pelvic surgery for either infertility or infection?			
9. Do you have any chronic medical conditions that require medication?			

SECTION III - Infections

	*Yes	No	Unk
10. Do you have a history of pelvic infection requiring hospitalization?			
11. Do you currently have or have you ever had or been exposed to tuberculosis? Have you ever lived with anyone who had tuberculosis?			
12. Do you currently have or have you ever had or been exposed to any sexually transmitted diseases including chlamydia, herpes, gonorrhea, syphilis, venereal warts, HPV, or HIV?			
13. Do you currently have or have you ever had a kidney or bladder problem, urinary tract infection, or cystitis?			
14. Do you currently have or have you ever had or been exposed to hepatitis?			
15. Have you had a rash or viral illness since your last menstrual period?			
16. Were you stationed overseas?			
17. Were you born outside of the United States?			
18. Do you live in a house with cats?			

SECTION IV - Domestic Abuse

	*Yes	No	Unk
19. Within the last year, have you been hit, slapped, or kicked?			
20. Since you learned that you are pregnant, have you been hit, slapped, or kicked?			
21. Within the last year have you been forced to participate in sexual activity?			
22. Do you live with anyone who hits you or hurts you in any way?			

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)

*Please explain any "Yes" response:

SECTION V - Family Health History	*Yes	No	Unk
23. Have you, the baby's father, or anyone in either of your families ever had any of the following:			
a. Multiple births?			
b. Lupus or autoimmune disease?			
c. Down syndrome (mongolism)?			
d. Neural tube defect (for example, spina bifida or meningomyelocele)?			
e. Baby born with anencephaly (without a brain or skull)?			
f. Hemophilia or other bleeding disorders?			
g. Muscular dystrophy?			
h. Cystic fibrosis?			
i. Sickle cell disease or trait?			
j. Mental retardation?			
k. Any other chromosomal abnormality or birth defect not listed?			
SECTION VI - Social & Lifestyle History	*Yes	No	Unk
24. Do you ever drive or ride in a car without wearing a seat belt?			
25. Do you use tobacco?			
a. Do you want to quit?			
b. Have tobacco cessation materials been offered to you?			
26. Do you use alcohol? How much? _____ Type: _____			
27. Have you ever used street drugs such as marijuana, LSD, speed, heroin, crystal, crack, cocaine, ecstasy, etc.?			
28. Have you taken any medications since becoming pregnant (including all prescription and nonprescription drugs)?			
29. Over the last two weeks have you felt: <input type="checkbox"/> Down, depressed, or hopeless? <input type="checkbox"/> Little interest or pleasure in doing things?			
30. What is the highest level of education you completed? _____			
31. What is your occupation? _____			
32. Since becoming pregnant, have you been exposed to x-rays or toxic chemicals?			
33. What is your primary language? _____			
34. What is your religion (optional)? _____			
SECTION VII - Menstrual History	*Yes	No	Unk
35. When was the first day of your last normal menstrual period? _____			
36. Are your periods usually regular? How long do your periods last? _____			
37. What type of birth control, if any, did you last use? _____ When? _____			
SECTION VIII - Pregnancy History	*Yes	No	Unk
38. Is this a planned pregnancy? _____			
39. How many pregnancies have you had including this one? _____			
40. How many preterm deliveries have you had (born more than 3 weeks before the baby's due date)? _____			
41. a. How many live births have you had? _____			
b. How many living children do you have? _____			
42. How many have you had? a. Still births _____ b. Abortions _____ c. Miscarriages _____			
* Please explain any "Yes" response: _____ _____ _____ _____			
Patient's Signature/Date _____		Provider's Signature/Date _____	

MEDICAL RECORD - PRENATAL SOCIAL NEEDS AND NUTRITION ASSESSMENT

For use of this form, see MEDCOM Circular 40-16

This form is to be completed by the patient

Please answer the following questions. The information you provide will help us better plan your care. If you need help with the completion of this form, please ask any member of the staff.

SECTION I - PRENATAL SOCIAL NEEDS ASSESSMENT

- 1. **Marital status:** Married Single Widowed Divorced Separated
- 2. **I live with my:** Husband Boyfriend Parents Roommate By myself
- 3. **Will your partner be deployed during your pregnancy?** Yes No Not applicable
- 4. **Will you be moving from this area during your pregnancy?** Yes No
When? _____ Where to? _____
- 5. **I live in:** Base Housing BEQ/BOQ Apartment Home Other (please specify): _____
- 6. **I am happy with my living accommodations:** Yes No
- 7. **I have lived in the current area for:**
 Less than a month 1-6 months 7-12 months Over a year
- 8. **I have supportive family/friends in this local area:** Yes No
- 9. **My partner's response to this pregnancy:**
 Very supportive Somewhat supportive Not supportive Not applicable
- 10. **My primary means of transportation is:**
 Own car Partner's car Friend's car Public transportation
- 11. **My current financial status is:** Good Fair Poor
- 12. **If this pregnancy was unplanned, which of the following have you considered?**
 Keeping the child Adoption Abortion Foster placement
- 13. **This is my first pregnancy:** Yes No
- 14. **How many children live with you?** _____ **Children's ages:** _____
- 15. **What is your biggest concern right now?**

16. **How are you adjusting / dealing with this concern?**

17. **Please let us help you by sharing your concerns. Check any of the following areas in which you might need information / assistance:**

- | | |
|--|--|
| <input type="checkbox"/> Money | <input type="checkbox"/> Baby items |
| <input type="checkbox"/> Babysitting | <input type="checkbox"/> Legal assistance |
| <input type="checkbox"/> Career help | <input type="checkbox"/> Obtaining food |
| <input type="checkbox"/> Counseling | <input type="checkbox"/> Parenting classes |
| <input type="checkbox"/> Family planning | <input type="checkbox"/> Safety concerns |
| <input type="checkbox"/> Goal setting | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Housing | <input type="checkbox"/> Other (please specify): _____ |

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)

SECTION II - PRENATAL NUTRITION ASSESSMENT

Your nutrition can have an important effect on your baby's health. Please answer these questions by checking the answers that apply to you.

Part A - DIET HISTORY

18. What was your weight before pregnancy? _____ What is your weight today? _____
19. Are you frequently bothered by any of the following? (Check all that apply)
 Nausea Vomiting Heartburn Constipation
20. Do you have children less than 12 months old? Yes No
 If so, are you breast feeding? Yes No
21. Do you have food allergies or intolerances? Yes No
22. Are you a vegetarian? Yes No
23. How would you describe your eating habits? Very good Good Poor
24. Are you having any unusual cravings for non-food items? Yes No
25. Have you ever had an eating disorder such as bulimia or anorexia? Yes No

Part B - FOOD RESOURCES

26. Are you receiving any food assistance now? (Check all that apply)
- | | | | |
|--|---|---------------------------------------|------------------------------------|
| <input type="checkbox"/> Donated food/commodities | <input type="checkbox"/> School breakfast | <input type="checkbox"/> School lunch | <input type="checkbox"/> WIC |
| <input type="checkbox"/> Food stamps | <input type="checkbox"/> Food pantry | <input type="checkbox"/> Soup kitchen | <input type="checkbox"/> Food bank |
| <input type="checkbox"/> Other (please specify): _____ | | | |

Part C - FOOD and DRINK

27. What did you eat yesterday?

Food	Amount
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

28. What did you drink yesterday?

Beverage	Amount
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

29. Is the way you ate yesterday the way you usually eat? Yes No

Patient's Signature/Date

Provider's Signature/Date

MEDICAL RECORD - CONSENT FORM
Cystic Fibrosis Carrier Test

For use of this form see MEDCOM Cir 40-16

I understand I am being asked to decide whether or not to have the cystic fibrosis carrier test. This test can identify if someone is a carrier of this disease.

By signing below I understand that--

1. This test is to see if I am a carrier of cystic fibrosis (CF). This means I could have the gene but not the disease.
2. The risk of being a CF carrier depends on race and ethnic background.
 - a. For European Caucasian and Ashkenazi Jewish couples:
 - (1) There is a 1 in 25 chance one parent is a carrier.
 - (2) There is a 1 in 625 chance both parents are carriers.
 - b. For Hispanic American couples:
 - (1) There is a 1 in 46 chance one parent is a carrier.
 - (2) There is a 1 in 2,116 chance both parents are carriers.
 - c. For African American couples:
 - (1) There is a 1 in 65 chance one parent is a carrier.
 - (2) There is a 1 in 4,225 chance both parents are carriers.
 - d. For Asian American couples:
 - (1) There is a 1 in 80 chance one parent is a carrier.
 - (2) There is a 1 in 8,100 chance both parents are carriers.
3. If I am a carrier of CF, testing the baby's biological father is needed to know if my baby could have CF.
4. CF carrier testing is one type of DNA testing. In the event the father is determined to be another person, a family medical history from that person will be necessary.
5. If both parents are carriers, the baby has 1 in 4 (25%) chance of having CF. If this is the case, I may have more testing to tell whether my baby has CF. This testing may be done before or after delivery.
6. I am the one to decide whether or not I am tested.
7. The test is not perfect. Some carriers are missed by the test.
8. My decision to have or not have this test will not change my military health coverage.

I have read and understand the information provided to me about cystic fibrosis. My questions have been answered to my satisfaction. Please check one:

- Yes, I want to have the cystic fibrosis carrier test.
- No, I do not want to have the cystic fibrosis carrier test.

Patient: _____
(Signature) (Print Name) (Date)

Witness: _____
(Signature) (Print Name) (Date)

MEDICAL RECORD - CONSENT FORM

Maternal Serum Analyte Screen

For use of this form see MEDCOM Cir 40-16

I understand I am being asked to decide whether or not to have the maternal serum analyte screen. The maternal serum analyte screen tests for substances made by the baby and the placenta. The amount of these substances in the blood is used to determine the risk of certain conditions in the baby. These conditions include open neural tube defects, Down syndrome (Trisomy 21), Edward's syndrome (Trisomy 18), and other related defects.

By signing below, I understand that--

1. This is a screening test only. It DOES NOT provide a diagnosis. It only predicts the chance of a certain condition occurring.
2. The maternal serum analyte screen tests for the risk of certain conditions in the baby. These conditions include open neural tube birth defects, Down syndrome, Edward's syndrome, and other related birth defects.
3. The maternal serum analyte screen is not 100% accurate. Some defects are missed. The results may be abnormal when the baby actually does not have one of these conditions. If there are abnormal results, I will need further testing to know more about my baby's health.
4. An open neural tube defect is an abnormality of the spinal cord or brain. This occurs in 1 or 2 of every 1000 births. If there is an abnormal result on the maternal serum analyte screen, my baby has a 4% to 7% risk of having an open neural tube defect.
5. Babies with Down syndrome have a distinct physical appearance, mental retardation, and an increased risk for other birth defects. About 1 in 800 babies have Down syndrome. The risk increases with maternal age. If there is an abnormal maternal serum analyte screen result, the baby has a 1% to 2% risk of having Down syndrome.
6. Babies with Edward's syndrome have serious mental and physical disabilities. Most affected babies do not live past their first year. Only 1 in 8000 babies are born with Edward's syndrome.
7. I am the one to decide whether or not I am tested.

I have read and understand the information provided to me about the maternal serum analyte screen. My questions have been answered to my satisfaction. Please check one:

Yes, I want to have the maternal serum analyte screen.

No, I do not want to have the maternal serum analyte screen.

Patient: _____
(Signature) (Print Name) (Date)

Witness: _____
(Signature) (Print Name) (Date)

MEDICAL RECORD - CONSENT FORM
Human Immunodeficiency Virus (HIV) Test

For use of this form see MEDCOM Cir 40-16

I understand I am being asked to decide whether or not to have the HIV test. HIV causes Acquired Immunodeficiency Syndrome (AIDS). This test shows if I have been infected with HIV.

By signing below, I understand that--

1. The HIV test detects antibodies to the Human Immunodeficiency Virus. HIV causes AIDS.
2. The HIV test is not 100% accurate. It can show a false positive when there is no infection. It can be a false negative when there really is an infection.
3. If I test positive, further testing is required.
4. If my test is truly positive, this does not mean that I have AIDS or will develop AIDS. It does mean that I could give HIV to another person.
5. If diagnosed with HIV, my treatment during pregnancy, labor and delivery, and treatment of my baby during the first 6 weeks of life can decrease the chance of my baby developing AIDS.
6. The Department of Defense has directed that all Active Duty patients receive HIV testing. For civilians, HIV testing is encouraged but not required.
7. HIV test results have caused some individuals to be denied insurance coverage. I understand that my military coverage will not be changed.

I have read and understand the information provided to me about HIV testing. My questions have been answered to my satisfaction. Please check one:

- Yes, I want to have the test for HIV.
- No, I do not want to have the test for HIV.

Patient: _____
(Signature) (Print Name) (Date)

Witness: _____
(Signature) (Print Name) (Date)