

**Birth Record
PRENATAL CARE WORKSHEET**

MOTHER				
Name	First	Middle	Last	Suffix

Maiden Name	Date of Birth / / (MM/DD/YYYY)	Social Security #
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MOTHER HEALTH				
Height _____ ft. _____ in.	Weight (pre-pregnancy) _____ lbs.	Cigarette Smoking	# of cigarettes per day	Alcohol use during this pregnancy <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Average number of drinks per week: _____
		3 months <u>before</u> pregnancy	# _____ Cigarettes	
		1 st 3 months of pregnancy	# _____ Cigarettes	
		2 nd 3 months of pregnancy	# _____ Cigarettes	
		3 rd 3 months of pregnancy	# _____ Cigarettes	

PRENATAL			
Date of Last Menses ____ / ____ / ____ MM DD YYYY	Prenatal Care No prenatal care <input type="checkbox"/> Date of 1 st visit ____ / ____ / ____ Total # of visits _____	Previous Live Births Number now living _____ Number now dead _____ Date of last live birth ____ / ____	Other Pregnancy Outcomes (Spontaneous or induced terminations or ectopic pregnancy) Combined number of other outcomes _____ Date of last other outcome ____ / ____

PREGNANCY FACTORS	
Risk Factors <input type="checkbox"/> Diabetes – Pre-pregnancy <input type="checkbox"/> Diabetes – Gestational (Diagnosis in this pregnancy) <input type="checkbox"/> Hypertension – Pre-pregnancy (Chronic) <input type="checkbox"/> Hypertension – Gestational (PIH, Pre-eclampsia) <input type="checkbox"/> Hypertension – Eclampsia	<input type="checkbox"/> Previous Preterm Births (<37 Completed Weeks Gestation) <input type="checkbox"/> Pregnancy Resulted From Infertility Treatment – Fertility-enhancing drugs <input type="checkbox"/> Pregnancy Resulted From Infertility Treatment – Assisted Reproductive Technology <input type="checkbox"/> Mother Had A Previous Cesarean Delivery <input type="checkbox"/> None Of The Above

Mother tested for: <input type="checkbox"/> HIV <input type="checkbox"/> Syphilis <input type="checkbox"/> Group B Strep	Infections Present and/or Treated <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Syphilis <input type="checkbox"/> Chlamydia <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C <input type="checkbox"/> None of the above	Obstetric Procedures <input type="checkbox"/> Cervical cerclage <input type="checkbox"/> Tocolysis External cephalic version: <input type="checkbox"/> Successful <input type="checkbox"/> Failed <input type="checkbox"/> None of the above
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PRENATAL CARE PROVIDER	
Name _____	Today's Date _____
Office Name _____	
Address _____	
Phone _____	Email _____