The Smart Mother's Guide®
WITH LINDA BURKE, MD
PREGNANCY EXPERT

Patient Addressograph

Date: – – ID #:

ANTEPARTUM RECORD

Hospital of Delivery:

Name:
LAST FIRST MIDDLE

Newborn Care Provider:	Referred By:
Primary Care Provider/Group:	Address:
Final EDD:	
Birth Date: – – Age: Race: Marital Status: S M W D Sep	Address:
	Zip: Phone: (1) (2)
Occupation: Education: (Last Grade Completed)	E-Mail:
Language: Ethnicity:	Insurance Carrier/Medicaid #:
Partner: Phone:	Policy #:
Father Of Baby: Phone:	Emergency Contact: Phone:

Total Preg:	Full Term:	Premature:	Ab, Induced:	Ab, Spontaneous:	Ectopic Pregnancy:	Multiple Births:	Living:

Menstrual History

Lmp ☐ Definite ☐ Approximate (Month Known) ☐ Unknown ☐ Normal Amount/Duration ☐ Final: _____

Duration: Q _____ Days

Prior Menses: _____ Date

Frequency: Q _____ Days

Contraception at pregnancy ☐ Yes ☐ No

Menarche: _____ (Age Onset)

Hcg + ___/___/___

Past Pregnancies (Last Five)

Date Month/ Year	GA Weeks	Length Of Labor	Birth Weight	Sex M/F	Type Of Delivery	Anes	Place Of Delivery	Breastfeeding Duration	Lactation Consult Needed Yes/No	Comments/ Complications

Medical History

	P*	F*	Detail Positive Remarks Include Date & Treatment
A. Drug/Latex Allergies/ Reactions	☐	☐	
B. Allergies (Food, Seasonal, Environmental)	☐	☐	
1. Neurologic/Epilepsy	☐	☐	
2. Thyroid Dysfunction	☐	☐	
3. Breast Disease/Breast Surgery	☐	☐	
4. Pulmonary (TB, Asthma)	☐	☐	
5. Heart Disease	☐	☐	
6. Hypertension	☐	☐	
7. Cancer	☐	☐	
8. Hematologic Disorders	☐	☐	
9. Anemia	☐	☐	
10. Gastrointestinal Disorders	☐	☐	
11. Hepatitis/Liver Disease	☐	☐	
12. Kidney Disease/UTI	☐	☐	
13. Deep Vein Thrombosis	☐	☐	
14. Diabetes (Type 1 Or Type 2)	☐	☐	
15. Gestational Diabetes	☐	☐	
16. Autoimmune Disorders	☐	☐	
17. Dermatologic Disorders	☐	☐	
18. Operations/Hospitalizations (Year & Reason)	☐	☐	
19. Gyn Surgery (Year & Reason)	☐	☐	
20. Anesthetic Complications	☐	☐	
21. History Of Blood Transfusions	☐	☐	
22. Infertility	☐	☐	
23. Art (IVF Or FET)	☐	☐	
24. History of Abnormal Pap	☐	☐	
25. History of STI	☐	☐	
26. Psychiatric Illness	☐	☐	
27. Depression/Postpartum Depression	☐	☐	
28. Trauma/Violence	☐	☐	
29. Tobacco (Smoked, Chewed, ENDS, Vaped) (AMT/Day)	☐	☐	
30. Alcohol (AMT/Wk)	☐	☐	
31. Drug Use (Including Opioids) (Uses/Wk)	☐	☐	
32. Polycystic Ovary Syndrome	☐	☐	
33. Other	☐	☐	

Prepreg	Preg	# Years Use

*P= Personal, F= Family

COMMENTS: _____

Patient Name:		Birth Date: – –	ID No.:	Date: – –

Genetic Screening*

Condition	Patient	Partner	Other	Relationship
Congenital Heart Defect				
Neural Tube Defect				
Hemoglobinopathy Or Carrier				
Cystic Fibrosis				
Chromosome Abnormality				
Tay–Sachs				
Hemophilia				
Intellectual Disability/Autism				
Recurrent Pregnancy Loss/Stillbirth				
Other Structural Birth Defect				
Other Genetic Disease (eg, PKU, Metabolic Disease, Muscular Dystrophy)				

Teratogen Exposures Since LMP/Pregnancy

	Yes	No	Details/Date
Prescription Medications			
Over The Counter Medications			
Alcohol			
Illicit Drugs			
Maternal Diabetes			HGB A1C
Other			
Uterine Anomaly/DES			

*If a patient has been screened for a genetic disorder previously, the results should be documented but the test should not be repeated.

COMMENTS/COUNSELING: _____

Infection History

	Yes	No
1. Live with Someone with TB or Exposed to TB		
2. Patient or Partner Has History of Genital Herpes		
3. Rash or Viral Illness Since Last Menstrual Period		
4. Prior GBS-Infected Child		
5. History of STIs: (Check All That Apply) ☐ Gonorrhea ☐ Chlamydia ☐ HPV ☐ Syphilis ☐ PID		

	Yes	No
6. HIV Infection		
7. History Of Hepatitis		
8. Recent Travel History or Partner Travel Outside of Country		
9. Recent Exposure to Zika Virus, Including by Partner. Assess at each prenatal visit. Check cdc.gov/zika for updates.		
10. Other (See Comments)		

COMMENTS: _____

_____ INTERVIEWER'S SIGNATURE: _____

Immunizations

Immunizations	Yes (Month/Year) ____ / ____	No	If No, Vaccine Indicated?*
Tdap (Each pregnancy; as early in the 27–36-weeks-of-gestation window as possible)			
Influenza† (Each pregnancy as soon as vaccine is available)			
Varicella†			
MMR (Rubella-containing vaccine)†			
HPV			

Immunizations	Yes (Month/Year) ____ / ____	No	If No, Vaccine Indicated?*
Hepatitis A (When Indicated)			
Hepatitis B (When Indicated)			
Meningococcal (When Indicated)			
Pneumococcal (When Indicated)			

*Yes/No and date to be administered

†All live vaccines are contraindicated in pregnancy, including the live intranasal influenza, MMR, and varicella vaccines. All women who will be pregnant during influenza season (October through May) should receive inactivated influenza vaccine at any point in gestation. Administer the HPV, MMR, and varicella vaccines postpartum if needed. The Tdap vaccine can be given postpartum if the woman has never received it as an adult and did not get it during pregnancy.

Initial Physical Examination

Date: _____ / _____ / _____ BP/Prepregnancy Weight: _____ Height: _____ BMI: _____

1. Heent	☐	Normal	☐	Abnormal	11. Vulva	☐	Normal	☐	Condyloma	☐ Lesions
2. Teeth	☐	Normal	☐	Abnormal	12. Vagina	☐	Normal	☐	Inflammation	☐ Discharge
3. Thyroid	☐	Normal	☐	Abnormal	13. Cervix	☐	Normal	☐	Inflammation	☐ Lesions
4. Breasts	☐	Normal	☐	Abnormal	14. Uterus Size		Weeks			☐ Fibroids
5. Lungs	☐	Normal	☐	Abnormal	15. Adnexa	☐	Normal	☐	Mass	
6. Heart	☐	Normal	☐	Abnormal	16. Rectum	☐	Normal	☐	Abnormal	
7. Abdomen	☐	Normal	☐	Abnormal	17. Clinical Pelvimetry	☐	Concerns	☐	No Concerns	
8. Extremities	☐	Normal	☐	Abnormal						
9. Skin	☐	Normal	☐	Abnormal						
10. Lymph Nodes	☐	Normal	☐	Abnormal						

COMMENTS (Number and explain abnormals): _____

_____ EXAM BY: _____

Patient Name:		Birth Date: – –	ID No.:	Date: – –

Drug Allergy:_____	Latex Allergy ☐ Yes ☐ No	Postpartum Contraception Method:_____ Counseled About LARC? ☐ Yes ☐ No

Is Blood Transfusion Acceptable? ☐ Yes ☐ No		Antepartum Anesthesia Consult Planned ☐ Yes ☐ No

Problems	Plans	Resolved?
1.		
2.		
3.		
4.		
5.		

Medication List (Including Opioids)	Start Date	Stop Date
1.	– –	– –
2.	– –	– –
3.	– –	– –
4.	– –	– –
5.	– –	– –

EDD Confirmation							Pregnancy Weight Gain	
Lmp:	– –	=		= EDD	– –		Prepregnancy Weight	
Initial Exam:	– –	=		Wks = EDD	– –		Height	
Ultrasonography:	– –	=		Wks = EDD	– –		BMI	
Final EDD:	– –	IVF Transfer:			– –		Estimated Weight Gain	
Initialed By:							Recommended Weight Gain	