OKLAHOMA DEPARTMENT OF CORRECTIONS
ANTEPARTUM RECORD

Date: ________________________ **Final EDD:** _______________________________

Birth Date (Month, Day, Year)	Age	Race	Marital Status (Circle) S M W D Sep	Emergency Contact Name Address City State Zip Phone ( )
Husband/Father of Baby		Phone ( )		

Total Pregnancies	Full Term	Premature	Abortions Induced	Abortions Spontaneous	Ectopics	Multiple Births	Living

MENSTRUAL HISTORY

LMP ☐ Definite ☐ Approximate (month known) ☐ Menses Monthly ☐ Yes ☐ No Frequency: O_____ days Menarche _______ (Age Onset)

☐ Unknown ☐ Normal Amount/Duration Prior Menses _______________Date On BCP'S at Concept ☐ Yes ☐ No HCG + ___/___/___

PAST PREGNANCIES

Date MO/YR	GA Weeks	Length of Labor	Birth Weight	Type Delivery	Anes.	Place of Delivery	Perinatal Mortality Yes/No	Treatment Preterm/Labor Yes/No	Comments/ Complications

PAST MEDICAL HISTORY

	O Neg. + Pos.	Detail Positive Remarks Include Date & Treatment		O Neg. + Pos.	Detail Positive Remarks Include Date & Treatment
1. Diabetes			16. (D) Rh Sensitized		
2. Hypertension			17. Pulmonary (TB, Asthma)		
3. Heart Disease			18. Allergies (Drugs)		
4. Autoimmune Disorder			19. Breast		
5. Kidney Disease/UTI			20. GYN Surgery		
6. Neurologic/Epilepsy			21. Operations/Hospitalization (Year & Reason)		
7. Psychiatric					
8. Hepatitis/Liver Disease					
9. Varicosities/Phlebitis			22. Anesthetic Complications		
10. Thyroid Dysfunction			23. History of Abnormal Pap		
11. Major Accidents			24. Uterine Anomaly/DES		
12. History of Blood Transfusion			25. Infertility		

	AMT/DAY Prepreg	AMT/DAY Prepreg	# YRS USE			
				26. Relevant Family History		
13. Tobacco						
14. Alcohol				27. Other:		
15. Street Drugs						

Comments: ____

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Offender Name: **DOC #:**
(Last, First)

ANTEPARTUM RECORD (Continuation)

SYMPTOMS SINCE LAST LMP	

GENETICS SCREENING/TERATOLOGY COUNSELING
Includes offender, baby's father, or anyone in either family with:

Check Appropriate box:	Yes	No	*Check appropriate box:*	Yes	No
1. Offender's age ≥ 35 years			10. Huntington Chorea		
2. Thalassemia (Italian, Greek, Mediterranean, or Asian background): MCV , 80			11. Intellectual Disability		
3. Neural Tube Defect (Meningomyelocele, Spina Bifida or Anencephaly)			If yes, was person tested for Fragile X?		
4. Down Syndrome			12. Other Inherited genetic or chromosomal disorder		
5. Tay-Sachs (e.g., Jewish, Cajun, Fr. Canadian)			13. Offender or baby's father has a child with birth defects not Listed above		
6. Sickle Cell Disease or Trait (African)			14. ≥ 3 first-trimester spontaneous abortions or a stillbirth		
7. Hemophilia			15. Medications/street drugs/alcohol since last menstrual period		
8. Muscular Dystrophy			If yes, agent(s)		
9. Cystic Fibrosis			16. Any other:		

Comments/Counseling:____

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INFECTION HISTORY					
Check Appropriate box:	Yes	No	*Check appropriate box:*	Yes	No
1. High risk for HIV			5. Rash or viral illness since last menstrual period		
2. High risk Hepatitis B/Immunized			6. History of STD's GC, Chlamydia, HPV, Syphilis		
3. Live with someone with TB or exposed to TB			7. Hepatitis C and/or father of baby Hepatitis C		
4. Offender or partner has history of genital herpes					

Comments: ____

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Interviewer's Signature: ______________________________ **Date**: ______________

INITIAL PHYSICAL EXAMINATION

Date: _______/______/_______ **Prepregnancy weight:** ___________ **Height:** ____________ **Blood Pressure:** ____________

Check Appropriate Box:

1. HEENT	☐ Normal	☐ Abnormal	12. VULVA	☐ Normal	☐ Condyloma	☐ Lesions
2. FUNDI	☐ Normal	☐ Abnormal	13. VAGINA	☐ Normal	☐ Inflammation	☐ Discharge
3. TEETH	☐ Normal	☐ Abnormal	14. CERVIX	☐ Normal	☐ Inflammation	☐ Lesions
4. THYROID	☐ Normal	☐ Abnormal	15. UTERUS SIZE	___________ Weeks		
5. BREASTS	☐ Normal	☐ Abnormal	16. ADNEXA	☐ Normal	☐ Mass	
6. LUNGS	☐ Normal	☐ Abnormal	17. RECTUM	☐ Normal	☐ Abnormal	
7. HEART	☐ Normal	☐ Abnormal	18. DIAGONAL CONJUGATE	☐ Reached	☐ No	__________ CM
8. ABDOMEN	☐ Normal	☐ Abnormal	19. SPINES	☐ Average	☐ Prominent	☐ Blunt
9. EXTREMITIES	☐ Normal	☐ Abnormal	20. SACRUM	☐ Concave	☐ Straight	☐ Anterior
10. SKIN	☐ Normal	☐ Abnormal	21. SUBPUBIC ARCH	☐ Normal	☐ Wide	☐ Narrow
11. LYMPH NODES	☐ Normal	☐ Abnormal	22. GYNECOID PELVIC TYPE	☐ Yes	☐ No	

Comments: (Number and Explain Abnormal)____

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Provider's Signature: ______________________________**Date:** ______________

Offender Name:
(Last, First)

DOC #:

ANTEPARTMUM RECORD (Continuation)

Date: ___________________________

Drug/Food Allergy:

Problems/Plans	Medication List: Start Date Stop Date
1.	1.
2.	2.
3.	3.
4.	4.
EDD Confirmation	**18-20-Week EDD Update**
Initial EDD:	Quickening _____/_____/_____+20 wks = _____/_____/_____
LMP ______/_____/______ = EDD_____/_____/_____	Fundal Ht. at Umbil. _____/_____/_____+20 wks = _____/_____/_____
Initial Exam ______/_____/_____=______ Wks= EDD_____/_____/_____	FHT W/Fetoscope _____/_____/_____+20 wks = _____/_____/_____
Ultrasound ______/_____/_____=______ Wks= EDD_____/_____/_____	Ultrasound _____/_____/_____+20 wks = _____/_____/_____
Initial EDD ______/_____/______ Initialed by:_____________________	Final EDD _____/_____/_____+20 wks = _____/_____/_____

Visit Date ____ (Year)	Weeks Gest. (Best Est.)	Fundal Height (CM)	Presentation	FHR	Fetal Movement	Preterm Labor Signs/symptom: +=Present o= Absent	Cervix Exam (DiL/EFF/Sta)	Blood Pressure	Edema	Weight	Urine (Glucose/Albumin)	Next Appointment	Provider (Initials)			
											/					8-18 Weeks CVS/A MMIO/ MSAFP
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											/					
											/					
											/					
											/					24/28 Weeks Glucose Screen RhiG
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Comments: ____

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Offender Name: **DOC#**
(Last, First)

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ANTEPARTUM RECORD (Continuation)

INITIAL LABS	DATE	RESULTS	REVIEWED
Blood type		O A B AB	
D (Rh) type			
Antibody screen			
HCT/HGB		___________% ___________g/dt	
PAP Smear		☐ Normal ☐ Abnormal	
Rubella			
VDRL			
Urine culture/screen			
HbsAg			
OPTIONAL LABS			
HIV			
HGB Electrophoresis		AA AS SS AC SC AF ↑ A2	
Chlamydia			
PPD			
GC			
Sickle Cell screen			
Tay-Sachs			
Other:			
8-18-WEEK LABS (when indicated/elected)			
Ultrasound			
MSAFP/Multiple Markers			
Down Syndrome			
Amnio/CVS			
Karyotype		46,XX or 46, XY / Other _________	
Amniotic Fluid (AFP)		☐ Normal ☐ Abnormal	
24-28 WEEK LABS (when indicated)			
HCT/HGB		___________% ___________g/dt	
Diabetic screen		1 hr. ________________	
GTT (if screen abnormal)		__________FBS _________1 hr. __________2 hrs. ________3 hrs.	
D (Rh) Antibody Screen			
D Immune Globulin (RhIG) Given (28 weeks)		Signature:	
32-36 WEEK LABS			
Ultrasound			
VDRL			
GC			
HCT/HGB (recommended)		___________% ___________g/dt	
Chlamydia			
36 – 40 WEEK LABS			
Beta Hemolytic Streptococcus culture of vagina and rectum			

COMMENTS/ADDITIONAL LABS

PLANS/EDUCATION (Counseled ☐)

- ☐ Childbirth classes ____
- ☐ Labor signs ____
- ☐ Postpartum birth control ____
- ☐ Environmental/work hazards ______________________________________
- ☐ Tubal Sterilization____
- ☐ Nutrition counseling ____

Requests: ____
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Tubal Sterilization: Consent Signed ☐ Yes ☐ No Date: _____/____/____ Signature: ___________________________

Offender Name: (Last, First) **DOC #:**