MANITOBA PRENATAL RECORD — Part 1

MB Health # PHIN

Name	Date of Birth (D / M / Y)	Age

Address Postal Code

Phone # (Home) (Work) S / M / CL (Circle)

Education ≤8 9 10 11 12 >12 (circle highest grade completed) Occupation

Father's Full Name Occupation Age

Anticipated Site of Delivery

DATE

WARD

FULL NAME

YEAR OF BIRTH

HOSPITAL NUMBER

PHYSICIAN / MIDWIFE

Attending Physician / Midwife	Referring Physician / Midwife	Consultant	Physician / Midwife for Baby

INFORMED CONSENT: I understand that providing this information is necessary to assist the physician / midwife in planning my care throughout pregnancy, childbirth and postpartum. My personal information will be kept private, but may be shared with other professionals directly involved in my care except_____. This information, with all my personal identifiers removed, may be used in health care research. I understand that I can withdraw or revoke this consent at anytime in writing.

Mother's Signature Witness Date

OBSTETRICAL HISTORY

Grav	Para	Term	Preterm	Alive	SB	NND	T.Abort	S.Abort	Mult	Ectop

Year	Place	Delivered By	Gestation Weeks	Duration of Labour	Type of Delivery	Anaesth	Sex	Birth Weight	Present Health	Complications / Comments

FAMILY HISTORY

	YES	NO	COMMENTS
Congenital Abnormalities	☐	☐	
Genetic Disease (see over)	☐	☐	
Diabetes	☐	☐	
Hypertension	☐	☐	
Bleeding Disorders	☐	☐	
Twins	☐	☐	
Anaesth. Problems	☐	☐	
Mental Illness	☐	☐	
Depression	☐	☐	
Other	☐	☐	

SIGNIFICANT MEDICAL ILLNESSES

	YES	NO	COMMENTS
Cardiovascular	☐	☐	
Hypertension	☐	☐	
Diabetes	☐	☐	
Renal / Bladder	☐	☐	
Infections (e.g. herpes)	☐	☐	
Varicella	☐	☐	
T.B. / Exposure	☐	☐	
Infertility	☐	☐	
Epilepsy	☐	☐	
Thyroid Dysfunction	☐	☐	
Asthma	☐	☐	
Bleeding Disorders	☐	☐	
Transfusions	☐	☐	
Thrombosis / Phlebitis	☐	☐	
Mental Illness	☐	☐	
Depression	☐	☐	
Other	☐	☐	

SIGNIFICANT SURGICAL ILLNESSES

	YES	NO	COMMENTS
Cone Biopsy CX	☐	☐	
Pelvic Surgery	☐	☐	
Abdominal Surgery	☐	☐	
Fractured Pelvis	☐	☐	
Spinal Surgery	☐	☐	
Anaesth. Problems	☐	☐	
Other	☐	☐	

Current Medications

Allergies

PREGNANCY DATING

Contraception Type_____

Pregnancy test positive Date_____ Type_____

LMP D / M / Y

INITIAL EDD D / M / Y

Cycle _____(Days)

Certain Yes ☐ No ☐

Normal Yes ☐ No ☐

Pill Withdrawal Yes ☐ No ☐

Uterine size at first visit Weeks Expected ____ Weeks Actual ____

Ultrasound Yes ☐ No ☐

REVISED EDD D / M / Y

HISTORY AT FIRST VISIT

	YES	COMMENTS
Bleeding	☐	
Nausea / Vomiting	☐	
Abdominal Pain	☐	
Infection / STD	☐	
Other	☐	

PHYSICAL EXAMINATION

D M Y

Height ____ Pre-Preg. wt. _____ Pres. wt._____ B.P. ____

Check (✓) if normal

Heent	☐	Nipples	☐	Vulva	☐
Thyroid	☐	Breasts	☐	Vagina	☐
Teeth/gums	☐	Abdomen	☐	Cervix	☐
Chest	☐	Back / Ext.	☐	Uterus	☐
Heart	☐	Pelvic Adequacy	☐	Adnexae	☐

COMMENTS (Detail abnormal Findings)

LIFESTYLE & SOCIAL HISTORY

NUTRITIONAL CONCERNS Yes ☐ No ☐

- pre-conceptional folic acid Yes ☐ No ☐
- post-conceptional vitamins / folic acid Yes ☐ No ☐

SOCIAL ISSUES: See questionnaire

- stress score _____
- home situation concerns Yes ☐ No ☐
- support systems adequate Yes ☐ No ☐
- other (e.g. financial)
- C & FS involvement Yes ☐ No ☐

SMOKING Yes ☐ No ☐ If yes,

cigs/day _____

quit date _____ (D / M / Y)

second-hand smoke Yes ☐ No ☐

ALCOHOL USE Yes ☐ No ☐ If yes, see algorithm (over)

days/wk _____

drinks/day _____

quit date _____ (D / M / Y)

T-ACE score ____

STREET DRUG USE Yes ☐ No ☐ If yes,

Past ☐ Current ☐ Dependent ☐

type _____

quit date _____ (D / M / Y)

Referred to:

MANITOBA PRENATAL RECORD Part 2

Name | Date of Birth (D / M / Y) | EDD: | Allergies:

INFECTION SCREENING

SEROLOGY	RESULTS	DECLINED
Hepatitis B		☐
HIV		☐
(D / M / Y)		
• prev. test		
• if declined, why?		
Rubella		☐
Varicella (if history is negative)		☐
VDRL		☐
Other (e.g. Hepatitis C, Toxo)		

CERVIX

Chlamydia		☐
Gonorrhea		☐
Other		

VAGINA / RECTUM

Group B Strep		☐
• gestation done		
Other (e.g. Bacterial vaginosis)		
MSU		☐

PAP SMEAR: (Date)

Rh Mother: Lab No.: Rh Father:

	Initial	28wks	
Antibodies:			Rhlg: Date (D / M / Y)
Maternal Serum Screening (MSS)	Accepted ☐	Declined ☐	Results:
Amniocentesis / CVS:	Accepted ☐	Declined ☐	Results:

	Initial	28 wks	
Hgb			
Platelets			
Blood Sugar (50 g)		28 wks	Other
GTT (75 g)	Fast	1 hr.	2 hr.

RISK FACTORS

Age ☐ Parity ☐

PAST OBSTETRIC HISTORY

- PPH / Manual removal ☐
- Baby > 9 lbs (4082 gm) ☐
- Baby < 5 1/2 lbs (2500 gm) ☐
- Hypertension in Pregnancy ☐
- Previous Caesarean ☐
- Stillbirth or Neonatal Death ☐
- Gestational diabetes ☐
- Incompetent cervix ☐

ASSOCIATED CONDITIONS

- Previous gynaecological surgery ☐
- Chronic renal disease ☐
- Diabetes mellitus ☐
- Cardiac disease ☐
- Other medical disorders ☐
- Depression ☐

LIFESTYLE / SOCIAL ISSUES

- Nutrition ☐
- Smoking ☐
- Alcohol ☐
- Street drugs ☐
- Stress ☐
- Home situation ☐

PRESENT PREGNANCY

(e.g. twins, breech, diabetes)

ULTRASOUND / FETAL ASSESSMENT

Date	G.A.	% ile	BPS	Comment / Placental location

MISCELLANEOUS

PRENATAL EDUCATION

Previous ☐ This pregnancy ☐ None ☐

DATE D / M / Y	WT	BP SITTING	URINE P / S	GA WEEKS	FUNDUS CM.	PRES.	FH	FM	COMMENTS / LAB

DISCUSSION TOPICS

- Nutrition / Vitamins ☐
- Weight Gain ☐
- Dental Care ☐
- Smoking ☐
- Drugs (pres, OTC, street) ☐
- Alcohol ☐
- Activity ☐
- Work ☐
- Breastfeeding ☐
- Fetal Movement ☐
- Bowel / Bladder ☐
- Back ☐
- Sexual Activity ☐
- Labour ☐
- Birth plan ☐
- Coverage ☐
- Circumcision ☐
- Postpartum Support ☐
- Parenting ☐
- Contraception ☐
- Tubal Ligation ☐

GENETICS SCREENING

Includes mother, baby's father, or anyone in either family

Consider referral of positive responses to genetics

1. Mother's age > 35 years on EDD?	10. Maternal PKU?
2. Is there a history of consanguinity?	11. Cystic Fibrosis?
3. Italian, Greek, Mediterranean, or Asian background (thalassemia)?	12. Huntington Chorea?
4. Jewish (Tay Sach's)?	13. Mental Retardation?
5. African (Sickle Cell Disease or Trait)?	If yes, were Chromosomes tested, including Fragile X?
6. Neural Tube Defect (Meningomyelocele, open spine, or anencephaly)?	14. Other inherited genetic or chromosomal disorder?
7. Down Syndrome (Mongolism)?	15. Mother or baby's father had a child with birth defect not listed above, > 2 first trimester spontaneous abortions, or a stillbirth?
8. Hemophilia?	
9. Muscular Dystrophy?	

SCREENING FOR ALCOHOL USE

Do you use alcohol?

NO

YES

SCREENING QUESTIONS

1. In a typical week, on how many days do you drink?
2. On those days, how many drinks are usual?
3. Administer a standard screening test (e.g., T-ACE)

HIGH RISK:
Secondary prevention strategies

1. Urgent referral to specialized resources. *(priority given to prenatal patients)*
2. Continued follow up and support.

AT RISK:
Secondary prevention strategies

1. Brief interventions:
   a. ADVISE by providing personalized feedback to the patient.
   b. ADVISE the patient to stop or reduce drinking.
   c. ASSIST by providing the patient with material to facilitate change.
2. Refer to appropriate resources.

LOW RISK:
Primary prevention strategies

1. Promote zero tolerance for alcohol when planning or during pregnancy.

THE T-ACE QUESTIONNAIRE*

- **T OLERANCE** – How many drinks does it take to make you feel high? → *Score 2 for more than 2 drinks; Score 0 for 2 drinks or less*
- **A NNOYANCE** – Have people annoyed you by criticizing your drinking? → *Score 1 point for each YES answer to the following three questions.*
- **C UT DOWN** – Have you felt you ought to cut down on your drinking?
- **E YE OPENER** – Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?

High risk score = 2 or more points

The T-ACE questionnaire is an example of one systematic approach to alcohol screening.

Reference: Sokol R. et al. The T-ACE Questions, practical prenatal detection of risk drinking. *American Journal of Obstetrics and Gynecology, April 1989;160(4).*

NAME: DATE:

PERSONAL & FAMILY INFORMATION

Having a baby usually means changes in your family life. You may wish to discuss some of these changes with your health care provider. Please answer the questions the best way you can. This information will help you and your baby receive the best possible care. Your answers are confidential and will be kept private in your file.

Stress *(circle best answer)*

1. In the last month, how often have you felt that you were unable to control the important things in your life?

   Never 0 Almost never 1 Sometimes 2 Fairly often 3 Very often 4

2. In the last month, how often have you felt confident about your ability to handle your personal problems?

   Never 4 Almost never 3 Sometimes 2 Fairly often 1 Very often 0

3. In the last month, how often have you felt that things were going your way?

   Never 4 Almost never 3 Sometimes 2 Fairly often 1 Very often 0

4. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?

   Never 0 Almost never 1 Sometimes 2 Fairly often 3 Very often 4

(from Perceived Stress Scale. Cohen, Kamarck & Mermelstein, 1983)

Home Situation *(circle yes or no)*

1. Have you ever been emotionally or physically abused by your partner or someone important to you?

   Yes No

2. Within the last year, have you been hit, slapped, kicked, or otherwise physically hurt by someone?

   Yes No

3. Since you've been pregnant, have you been hit, slapped, kicked, or otherwise physically hurt by someone?

   Yes No

4. Within the last year, has anyone forced you to have sexual activities?

   Yes No

5. Are you afraid of your partner or anyone else?

   Yes No

(adapted from Abuse Assessment Screen. Soeken, McFarlane, Parker, & Lominack, 1998)

Social Support *(check best answer)*

1. How does your partner / family feel about your pregnancy?

   - Very Happy / pleased ☐
   - Warming up to the fact ☐
   - Ambivalent (neither happy nor unhappy) ☐
   - Not really happy / pleased ☐
   - Upset / disappointed ☐

2. When you get home with your baby, who will be helping you? _____

3. How much help do you think you will receive?

   - No help ☐
   - Minimal help ☐
   - Quite a bit of help ☐
   - Lots of help ☐

(adapted from Antenatal Psychosocial Health Assessment (ALPHA), CMAJ 1998;159(6);680)

OFFICE CHART

NAME DATE OF BIRTH (D / M / Y)

DELIVERY SUMMARY

Date	Time	Sex	Weight

INDUCTION: Yes ☐ No ☐ Indication Method

LABOUR: Augmentation Yes ☐ No ☐ Duration

DELIVERY: Spontaneous ☐ VBAC ☐ Operative ☐

Complications

- Indication _____
- Type _____

PLACENTA: Spontaneous ☐ Manual Removal ☐

EPISIOTOMY / TEARS: Yes ☐ No ☐ Estimated Blood Loss

METHOD OF FEEDING: Breastfeeding ☐ Formula ☐

MATERNAL / NEWBORN COMPLICATIONS:

POST-PARTUM EXAMINATION

Date	Weight	B / P	Hgb	Urine

Lochia	Menses	Bladder & Bowel Function

BREAST EXAMINATION:

PELVIC EXAMINATION:

METHOD OF FEEDING: Breastfeeding ☐ Formula ☐

- Exclusive ☐
- Partial ☐

FAMILY PLANNING:

MATERNAL / NEWBORN COMPLICATIONS: