

PATIENT: _____ ALLERGIES: _____
 WIC: _____ HV: _____ INSURANCE: _____
 PHYSICIAN NAME: _____

PRENATAL CARE VISIT SUMMARY

Date Pregnancy confirmed: _____ Number of Previous Pregnancies: _____

High Risk Pregnancy: _____ Number of Live Births: _____

Estimated Date of Delivery: _____ Date Initial Lab Work Drawn: _____

	E.G.A.	Date Visit Completed	Follow-Up Needed	Follow-Up Complete
Initial OB Visit				
OB Visit				
OB Visit				
OB Visit				
OB Visit				
OB Visit				
OB Visit				
OB Visit				
OB Visit				
OB Visit				
OB Visit				
OB Visit				
OB Visit				
OB Visit				
OB Visit				

<u>Date of Delivery:</u> ____ / ____ / ____	<u>Delivery Method:</u> Vag. ____ C-Section ____ Apgar ____ ____	<u>Gender:</u> M ____ F ____	<u>Birth Weight:</u> ____ lbs. ____ oz.	<u>Length:</u> ____ inches	<u>Head Circumference:</u> ____
<u>Post Partum Exam:</u> ____ / ____ / ____	<u>Birth Control Method Discussed</u> _____	Bottle or Breast Feeding? _____	<u>Concerns:</u> _____	<u>Referrals:</u> _____	<u>Comments:</u> _____

Physician Signature: _____ Date: _____
 Street Address: _____ City/State/Zip: _____
 Physician Phone Number: _____ Fax Number: _____