

# British Columbia Antenatal Record Part 1

1. Hospital		Attending physician/midwife:		Referring physician/midwife:	
Mother's name			Date of birth (DD/MM/YYYY)	Age at EDD	
Mother's maiden name			Ethnic origin	Language preferred	
Occupation			Work hrs/day	No. of school yrs. completed	
Partner's name		Age	Ethnic origin of newborn's father	Partner's work	

Surname \_\_\_\_\_ Given name \_\_\_\_\_

Address \_\_\_\_\_

Phone number \_\_\_\_\_ Personal health number \_\_\_\_\_

2. **Allergies**  None known  Yes (reaction) \_\_\_\_\_ Medications/herbals \_\_\_\_\_ Beliefs & practices \_\_\_\_\_

3. Obstetrical History		Gravida	Term	Preterm	Abortion (Induced _____ Spontaneous _____)		Living	Children			
Date	Place of birth/abortion	Hrs. in labour	Gest. age	Type of birth	Perinatal complications			Sex	Birth Weight	Breastfed	Present health

4. LMP (DD/MM/YYYY) \_\_\_\_\_ Menses cycle \_\_\_\_\_ Contraceptives \_\_\_\_\_ When stopped (DD/MM/YYYY) \_\_\_\_\_ EDD by dates (DD/MM/YYYY) \_\_\_\_\_ Confirmed EDD (DD/MM/YYYY) \_\_\_\_\_ 1st US (DD/MM/YYYY) \_\_\_\_\_ GA by US (WEEKS + DAYS) \_\_\_\_\_

5. **Present Pregnancy**

*No*  IVF pregnancy \_\_\_\_\_ *Yes (specify)* \_\_\_\_\_

Bleeding \_\_\_\_\_

Nausea \_\_\_\_\_

Infections or fever \_\_\_\_\_

Other \_\_\_\_\_

6. **Family History**

*No*  Heart disease \_\_\_\_\_ *Yes (specify)* \_\_\_\_\_

Hypertension \_\_\_\_\_

Diabetes \_\_\_\_\_

Depression/psychiatric \_\_\_\_\_

Alcohol/drug use \_\_\_\_\_

Thromboembolic/coag. \_\_\_\_\_ *Maternal* *Newborn's Father*

Inherited disease/defect \_\_\_\_\_

Ethnic (e.g. Tay Sachs, Sickle) \_\_\_\_\_

Other \_\_\_\_\_

7. **Medical History**

*No*  Surgery \_\_\_\_\_ *Yes (specify)* \_\_\_\_\_

Anesthesia \_\_\_\_\_

Uterine/Cx procedure \_\_\_\_\_

STIs/infections \_\_\_\_\_

Susceptible to chicken pox \_\_\_\_\_

Thromboembolic/coag. \_\_\_\_\_

Hypertension \_\_\_\_\_

GI \_\_\_\_\_

Urinary \_\_\_\_\_

Endocrine/diabetes \_\_\_\_\_

Neurologic \_\_\_\_\_

Hx of mental illness \_\_\_\_\_

Anxiety  Depression  Bipolar

PP depression  Unknown  Other

Other \_\_\_\_\_

8. **Lifestyle & Social**

*Discussed*  Diet/Food Safety \_\_\_\_\_ *Concerns*

Folic acid \_\_\_\_\_

Physical Activity/rest/work \_\_\_\_\_

OTC drugs/vitamins \_\_\_\_\_

Alcohol  never  quit (DD/MM/YYYY) \_\_\_\_\_

Drinks/wk: before pregnancy \_\_\_\_\_ current \_\_\_\_\_

Binge drinking  No  Yes \_\_\_\_\_

TWEAK score \_\_\_\_\_ (see reverse)

Substance use  No  Yes \_\_\_\_\_

Heroin  Cocaine  Marijuana

Methadone  Solvents  Other \_\_\_\_\_

Prescription  Unknown \_\_\_\_\_

Smoking  never  quit (DD/MM/YYYY) \_\_\_\_\_

Cig/day: before pregnancy \_\_\_\_\_ current \_\_\_\_\_

Exposure 2nd hand smoke  No  Yes \_\_\_\_\_

Financial & housing \_\_\_\_\_

Support system \_\_\_\_\_

IPV \_\_\_\_\_

Public Health Nursing follow-up/assessment \_\_\_\_\_

9. **Physical Examination**

Date (DD/MM/YYYY) \_\_\_\_\_ BP \_\_\_\_\_ Height (cm) \_\_\_\_\_ Pre-pregnant weight (kg) \_\_\_\_\_ Pre-pregnant BMI \_\_\_\_\_

Head & neck \_\_\_\_\_ Musculoskeletal \_\_\_\_\_

Breasts & nipples \_\_\_\_\_ Varicels & skin \_\_\_\_\_

Heart & lungs \_\_\_\_\_ Pelvic exam \_\_\_\_\_

Abdomen \_\_\_\_\_ Swabs/cervix cytology \_\_\_\_\_

10. **First Trimester Topics Discussed:** \_\_\_\_\_ *Plans to breastfeed*

Prenatal Genetic Screening  Genetic counselling offered  HIV & other tests  Yes

Baby's Best Chance  Prenatal education  Breastfeeding  No

Seat belt use  Sexual relations  Maybe

11. **Summary**

SIGNATURE: \_\_\_\_\_ MD/MW \_\_\_\_\_

# British Columbia Antenatal Record Part 2

12. Intended place of birth	Alternate place of birth (Hospital)
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<b>13. Investigations / Result</b> ABO group Rh factor	Rubella titre <input type="checkbox"/> PP vaccination indicated	Prenatal Genetic Screening Type <b>Result</b>	
	S.T.S.		
	Antibody titre (DD/MM/YYYY) <b>Results</b> 1	HIV test done <input type="checkbox"/> Yes <input type="checkbox"/> No	Gest. diabetes screen (24–28 wks) (DD/MM/YYYY) <b>Result</b>
	2	HBsAg done (DD/MM/YYYY) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Negative <input type="checkbox"/> Positive	GBS screen (35–37 wks) <input type="checkbox"/> Yes <input type="checkbox"/> No (DD/MM/YYYY) <b>Result</b>
Rhlg given (DD/MM/YYYY) 1	<input type="checkbox"/> Partner/household contact <input type="checkbox"/> NB vaccination indicated	Edinburgh Postnatal Depression Scale (28–32 weeks) (DD/MM/YYYY) <b>Score</b>	
2	Other tests (e.g. Hep C, TSH, Varicella)	Follow-up <input type="checkbox"/> Yes <input type="checkbox"/> No	
Hemoglobin 1st <span style="float:right">3rd</span>			
Urine C & S result			

Surname	Given name
Address	
Phone number	Personal health number

**15. Potential or Actual Concerns:**

Lifestyle

Pregnancy

Labour

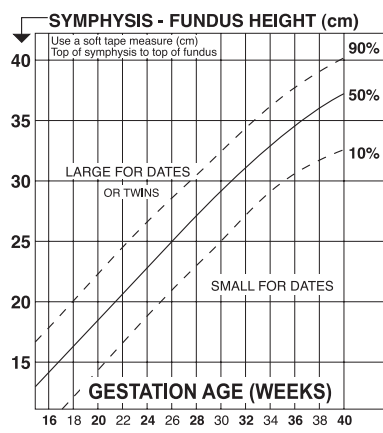
Breastfeeding

Postpartum

Newborn

14. Age	Pre-pregnant weight (KG)	Height (CM)	LMP (DD/MM/YYYY)	Confirmed EDD (DD/MM/YYYY)
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16. Date	B.P.	Urine	Wt. (KG)	Gest. wks.	Fundus (CM)	FHR	FM	Pres. and Pos.	Comments	Next visit
									Give Pregnancy Passport	
									1 <sup>st</sup> tri serum 10–13 <sup>+6</sup> wks / NT 11–13 <sup>+6</sup> wks	
									2 <sup>nd</sup> tri serum 15–20 <sup>+6</sup> weeks	
									At 20 wks copy to patient / to hospital	
									Reassess diet, physical activity, smoking, alcohol & substance use	
									Discuss fetal movement 26–32 wks	
									At 36 wks copy to patient / to hospital	



**17. Second & Third Trimester Topics Discussed**

<input type="checkbox"/> Call schedule	<input type="checkbox"/> Preterm labour	<input type="checkbox"/> Hospital admission	<input type="checkbox"/> Doula	<input type="checkbox"/> Breastfeeding
<input type="checkbox"/> Risks/benefits of planned or use of blood/blood products	<input type="checkbox"/> Birth plan	<input type="checkbox"/> VBAC	<input type="checkbox"/> Newborn screening: bloodspot/hearing	<input type="checkbox"/> Infant safe sleep
<input type="checkbox"/> Pain management	<input type="checkbox"/> Cesarean		<input type="checkbox"/> Infant car seats	

**18. Other Investigations & Comments**

1st US (DD/MM/YYYY)	GA by US (WEEKS + DAYS)	If maternal prenatal screen above cut-off, amnio: <input type="checkbox"/> Yes <input type="checkbox"/> No

SIGNATURE: \_\_\_\_\_ MD/MW