

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	Surname Given name
Mother's maiden name			Ethnic origin	Language preferred	Address
Occupation			Work hrs/day	No. of school yrs. completed	
Partner's name		Age	Ethnic origin of newborn's father	Partner's work	Phone number Personal health number

2. Allergies <input type="checkbox"/> None known <input type="checkbox"/> Yes (reaction)		Medications/herbals	Beliefs & practices
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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)
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5. Present Pregnancy

No Yes (specify) _____

IVF pregnancy _____

Bleeding _____

Nausea _____

Infections or fever _____

Other _____

6. Family History

No Yes (specify) _____

Heart disease _____

Hypertension _____

Diabetes _____

Depression/psychiatric _____

Alcohol/drug use _____

Thromboembolic/coag. _____

Inherited disease/defect _____

Ethnic (e.g. Tay Sachs, Sickle) _____

Other _____

Maternal Newborn's Father

7. Medical History

No Yes (specify) _____

Surgery _____

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 _____ Concerns _____ Referred _____

Diet/Food Safety _____

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:

<input type="checkbox"/> Prenatal Genetic Screening	<input type="checkbox"/> Genetic counselling offered	<input type="checkbox"/> HIV & other tests	Plans to breastfeed <input type="checkbox"/> Yes
<input type="checkbox"/> Baby's Best Chance	<input type="checkbox"/> Prenatal education	<input type="checkbox"/> Breastfeeding	<input type="checkbox"/> No
<input type="checkbox"/> Seat belt use	<input type="checkbox"/> Sexual relations		<input type="checkbox"/> 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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13. Investigations / Result	Rubella titre <input type="checkbox"/> PP vaccination indicated	Prenatal Genetic Screening Type Result
ABO group	S.T.S.	Gest. diabetes screen (24–28 wks) (DD/MM/YYYY) Result
Rh factor	HIV test done <input type="checkbox"/> Yes <input type="checkbox"/> No	GBS screen (35–37 wks) <input type="checkbox"/> Yes <input type="checkbox"/> No (DD/MM/YYYY) Result
Antibody titre (DD/MM/YYYY) Results	HBsAg done (DD/MM/YYYY) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Negative <input type="checkbox"/> Positive	Edinburgh Postnatal Depression Scale (28–32 weeks) (DD/MM/YYYY) Score
1	<input type="checkbox"/> Partner/household contact	Follow-up <input type="checkbox"/> Yes <input type="checkbox"/> No
2	<input type="checkbox"/> NB vaccination indicated	
Rhlg given (DD/MM/YYYY)	Other tests (e.g. Hep C, TSH, Varicella)	
1		
2		
Hemoglobin		
1st	3rd	
Urine C & S result		

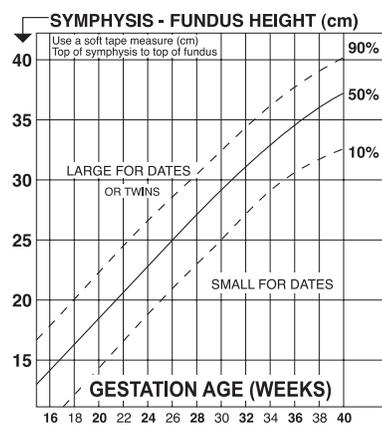
Surname	Given name
Address	
Phone number	Personal health number

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 st tri serum 10–13 ⁶ wks / NT 11–13 ⁶ wks	
									2 nd tri serum 15–20 ⁶ 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
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Surname	Given name
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Lifestyle

Pregnancy

Labour

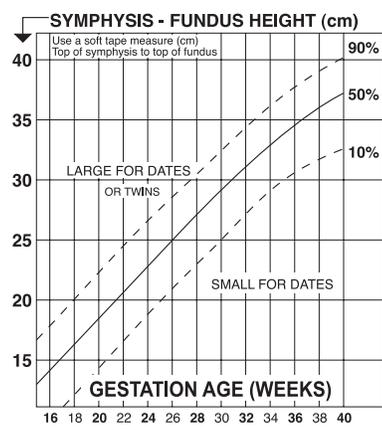
Breastfeeding

Postpartum

Newborn

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