

Pregnancy Passport

A Personal Pregnancy
Health Record



NYC
Health



Name	DOB
Address	Zip
Home Telephone	Cell Phone
OB Site	OB Telephone
OB Address	Provider Name
Planned Hospital for Delivery	
Emergency Contact	Relationship
Address	
Home Telephone	Cell Phone
Allergies	
Medications/Dosage	
G__ P__ __ __ __	
LMP	EDD
	Rev EDD

Delivery History				
Year	GA	BW	Del.Type/Incision Type for C/S	Complications

Counseling/Education	Date
1st HIV	
3rd trim HIV	
Tdap Vaccine	
Smoking	
Substance Abuse/Alcohol	
Domestic Violence	
Nutrition/Weight Gain	
Breastfeeding	
Lead Risk Assessment	
Other (specify)	

Screening Test	Date	Results
Type and Rh		
Rhogam (for Rh-)		
Hgb/Hct		
Hgb Elec		
Rubella		
Hep-B sAg		
VDRL/RPR		
GC/CT		
1st HIV		
3rd trimester HIV		
Pap Smear		
PPD		
CXR (for PPD+)		
1st Trimester Genetic Screen		
Quad Screen		
Other Genetic Tests (specify)		
GCT		
OGTT		
35w GBS		
Seasonal Influenza Vaccine		
Other (specify)		

Medical History	No	Yes	Details
Asthma			
Diabetes			
Hypertension			
Cardiac Disease			
Tuberculosis			
Active Hepatitis B			
Active Hepatitis C			
Syphilis			
HSV			
Other (specify)			

Obstetric History	Past	Present
GDM		
Preeclampsia/Eclampsia		
Hemorrhage or Blood Transfusion		
Fetal Anomaly (Type) _____		
Birth Injury (Type) _____		
Admission to ICU		
Other (specify)		

Sonography			
Date	EGA	Sono GA	Comments

Other Obstetric Information
Planned Method of Delivery
Planned Infant Feeding Method <input type="checkbox"/> Breast <input type="checkbox"/> Bottle <input type="checkbox"/> Both
Consent for Sterilization <input type="checkbox"/> Y <input type="checkbox"/> N (sign consent form at least 30 days before EDD)
Other (specify)

Problem List

Social Concerns

- Always carry this booklet with you
- Show this booklet at each visit
- Bring this booklet with you to the hospital