GOVERNMENT OF MEGHALAYA
HEALTH & FAMILY WELFARE DEPARTMENT

OBSTETRIC ANTE NATAL-CASE RECORD- DAY CARE

Hospital Name		District	
Patient's Name:		OPD/UHID No.	
Age:		Date of Reporting	
Wife of:		Date of Referral	
Address:		Place of Referral	
Occupation:		Contact No:	
Name of Consulting Doctor:			

1. Complaint of:

2. History of Amenorrhoea: - **Months:-__________Days:_____________**

3. Menstrual History: - **Regular/Irregular Cycles**
LMP:______________
EDD: ______________

4. Obstetric History: Gravida:__________/ Para:_________/ Abortion:__________ / Living:____________

Order of Delivery	Mode of Delivery	Complications(If any)	Outcome of Pregnancy
1			
2			
3			

5. Contraceptive History:

6.Past History:

7.Family History:

8.General Physical Examination:

Weight:-	**Pulse:-**	**BP:-**	**R R:-**	**Temp:-**
Pallor:-	Oedema:-	Jaundice:-	Breasts:-	Nipples:-Normal/Inverted
Any other findings:-				

9.Systemic examination

Cardio Vascular System:	
Respiratory System:	
Per Abdomen:	Fundal Height:
	Lie:
	Presentation:
	Foetal Heart Sound:
	Previous Scar/Any Other Observations:-
Any Other Systems(if needed):	

10.Vaginal Examination [If necessary]:

11.Provisional Diagnosis:

12. Laboratory Investigation (Optional):

Hb%:	Blood Group & Rh typing:	Urine Routine Examination:	VDRL:	HIV:
HBsAG:	USG Abdomen: (If required).			
Any other Investigations(If Required):-				

13. Prophylaxis:-

Tab. Iron & Folic Acid Tablet:-
Inj. Tetanus toxoid: - 1st. Dose:Date:_____________Month______________ Day_________________ 2nd dose:Date: _____________Month______________ Day_________________ Booster Dose: Date: _____________ Month ______________ Day ________________

14. Any other Treatment given:-

15. Counselling:-

ASSESSMENT GRADING		
Satisfactory ☐	**Unsatisfactory**	☐

Name of Doctor/Supervisor: ____

Signature & Seal of Doctor/ Supervisor: ____

Date: _____________

Time: _____________