

MEDICAL EXAMINATION FORM

(TO BE COMPLETED BY PHYSICIAN)

Date _____ Name _____

SS# _____ Date of Birth _____ Age _____

Address _____
City _____ State _____ Zip _____

Height _____ Weight _____ BP _____ Pulse _____

HISTORY: History of Previous Pregnancies _____

Complications _____

Medical/Surgical History _____

Pertinent Family History _____

PREGNANCY INFORMATION: *Confirmation of pregnancy:* Yes _____ No _____

Gravida _____ Para _____ LMP _____ EDC _____

Initial Pregnancy Risk Assessment None _____ Low Risk _____

Med. Risk _____ High Risk _____

Risk Factors Identified _____

CURRENT PHYSICAL EXAM: Blood Type/RH _____ RhoGam _____ Rubella Status _____

HIV _____ Hgb/Het _____ RPR _____ GC Culture _____ Hepatitis Screen _____

TB Test Results _____ Pap Smear _____ UA Drug Screen _____

Was OB Ultrasound performed: Yes _____ No _____ Findings/Data _____

Current Medication/Dosage _____

Allergies _____

Risk for communal living: High _____ Medium _____ Low _____

Due to: Physical condition _____ Drug use _____ Mental/emotional indicators _____

Communicable disease _____ Other _____

Physician Signature _____ Physician Printed Name _____

Address _____ Phone # _____