Stanford HEALTH CARE

Los Olivos Women's Medical Group

# Return OB visit

Name: _____ Date: _____ Routine OB ☐ Problem Visit ☐

**No change from last visit:** ☐

Are you high risk? Why? _____

**Please list any questions, symptoms, concerns or anything else that you would like to discuss. Any changes since your last visit?**

**Since your last visit, please check any of the following issues you currently have.**
**None** ☐ Decreased fetal movement ☐ Dizziness ☐ Shortness of breath ☐ Cramping ☐ Bleeding ☐

Other: _____

During this pregnancy you should have a flu shot and TdaP. Completed Flu shot ☐ Tdap ☐
It is recommended that you get the Tdap vaccination with every pregnancy between 27 and 36 weeks. I have registered at the hospital. ☐

**Current medications:** Prenatal vitamins ☐ Iron ☐ Other: _____

_____

**Pregnancy planning:**
Completed(C) or Enrolled (E): Birth classes ____ Hospital Tour ____ Not applicable☐

Name of pediatrician: _____

**Birth plan:**
Vaginal ☐ Cesarean section ☐ VBAC ☐ Tubal ligation ☐ Natural ☐ Epidural ☐
Scheduled Cesarean date: _____

**For Nursing and Doctors:**
Weight _____ B/P _____ urine: prot: _____ glu: _____ weeks preg: _____