Oregon Health Authority
PUBLIC HEALTH DIVISION
Center for Health Statistics

Birth Record
PRENATAL CARE WORKSHEET

MOTHER

Name (First / Middle / Last / Suffix)

Maiden Name

Date of Birth (MM/DD/YYYY) / /

Social Security #

MOTHER HEALTH

Height: _____ ft. _____ in.

Weight (pre-pregnancy): _____ lbs.

Cigarette Smoking — # of cigarettes per day
- 3 months before pregnancy #_____ Cigarettes
- 1st 3 months of pregnancy #_____ Cigarettes
- 2nd 3 months of pregnancy #_____ Cigarettes
- 3rd 3 months of pregnancy #_____ Cigarettes

Alcohol use during this pregnancy
☐ Yes ☐ No ☐ Unknown
Average number of drinks per week: _____

PRENATAL

Date of Last Menses: ____/____/____ (MM DD YYYY)

Prenatal Care
No prenatal care ☐
Date of 1st visit ____/____/____
Total # of visits _____

Previous Live Births
Number now living _____
Number now dead _____
Date of last live birth ____/_____

Other Pregnancy Outcomes
(Spontaneous or induced terminations or ectopic pregnancy)
Combined number of other outcomes _____
Date of last other outcome ____/_____

PREGNANCY FACTORS

Risk Factors
- ☐ Diabetes – Gestational
- ☐ Diabetes – Pre-pregnancy
- ☐ Hypertension – Pre-pregnancy (Chronic)
- ☐ Hypertension – Gestational (PIH, Preeclampsia)
- ☐ Hypertension – Eclampsia
- ☐ Previous Preterm Births (<37 Completed Wks. Gestation)
- ☐ Pregnancy Resulted From Infertility Treatment – Fertility-enhancing drugs
- ☐ Pregnancy Resulted From Infertility Treatment –Assisted Reproductive Technology
- ☐ Mother Had A Previous Cesarean Delivery How Many? _____
- ☐ None Of The Above

Mother tested for:
- ☐ HIV
- ☐ Syphilis
- ☐ Group B Strep

Infections Present and/or Treated
- ☐ Gonorrhea
- ☐ Syphilis
- ☐ Chlamydia
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ COVID-19 (Confirmed or Presumed)
- ☐ None Of The Above

Obstetric Procedures
- ☐ Cervical cerclage
- ☐ Tocolysis

External cephalic version:
- ☐ Successful ☐ Failed
- ☐ None of the above

PRENATAL CARE PROVIDER

Name _____ Today's Date _____

Office Name _____

Address _____

Phone _____ Email _____