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Preconception Checklist

Patient information

Name: ..... Age: .....

Adress: .....

Occupation: ..... Religion: .....

Obstetric - Gynecological history

Menarche: .....

Menstrual circle: .....

Menstrual days: .....

Menstrual blood volumn: .....

☐ Gynecological diseases. Specific: .....

☐ Sexually transmitted disease. Specific: .....

☐ Contraceptive method. Specific: .....

PARA: | | | | |

Medical-Surgical history

☐ Chronic disease, specific .....

☐ Surgery, specific .....

☐ Medication, specific.....

Family history

☐ Birth defect, specific .....

☐ Genetic disease, specific .....

Vaccinations

☐ MMR (Date:.....)

☐ Hepatitis B (Date:.....)

☐ Flu (Date:.....)

☐ Covid-19 (Date:.....)

☐ Chicken pox vacination (Date:.....)

☐ Other (Specific name.....Date:.....)

Healthy lifestyle

☐ Tobaco use ..... cigarette /day

☐ Alcohol use ..... glasses /day

☐ Drugs. (Specific.....)

☐ Physical activity ..... minutes /day

☐ Diet

- ☐ Water intake .....ml/day
- ☐ Folic acid suppliment (400mg/day)
- ☐ Eat fruit and vegetables everyday
- ☐ Vegetarian
- ☐ Soft drink
- ☐ Fastfood

☐ Relaxation (movie, music, travelling, ……..)

☐ Sleep time ……hour/day

Physical examination

Vital sign

BP: …… Pulse rate: ……..

Temperature: …… Breathing rate: ……

Weight: ……Height: ……BMI: ……..

Blood sample

Date	Laboratory test	Results	Date	Laboratory test	Results
	Hematology tests			Toxoplasma	
	Blood type (ABO/Rh)			HbsAg	
	Glucose			HIV	
	CMV			BW	
	Rubella				

Notes and Recommendation

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Midwife's name: ……**Signature:** ……