



THE REPUBLIC OF UGANDA

MINISTRY OF HEALTH
ANTENATAL CARD

Health Unit: _____ Reg no. _____
 Name: _____ NIN: _____
 Phone No: _____ Age: _____
 Village: _____ Parish: _____
 Sub- county: _____ District: _____
 Occupation: _____ Religion: _____
 Education level: _____ Tribe: _____
 Marital status: _____

Next of Kin:

Name: _____ Phone No. _____
 Relationship: _____ Address: _____

Gravida: _____ **Para:** _____ **Abortions:** _____

PRESENT PREGNANCY:

Presenting complaints _____

First Day of LNMP _____

EDD: _____

Weeks of Amenorrhea: _____

Complications of Pregnancy if any:

-Bleeding

-Excessive vomiting

Others Specify: _____

Any hospitalisation? YES /NO

If Yes; for _____

MENSTRUAL AND CONTRACEPTIVE HISTORY:

Length of menses (no. of days of bleeding)

Amount: Heavy/Normal

Family Planning method recently used before this pregnancy:

When and why was it discontinued?
 _____ If never used, why?

PREVIOUS ILLNESS/:

Has any of the following been present for over 2 weeks?

Cough, Fever, Weight loss, Night Sweats:

Known HIV status? YES/NO

Medical: Cardiac Disease: _____ **MEDICATIONS:**

Kidney Disease: _____ ARVs

Hypertension: _____ Others specify:

TB: _____

Asthma: _____

Thrombo embolic disorders: _____

STI:
 Sickle Cell Disease:
 Epilepsy (seizures):
 Diabetes:

Others specify:

Surgical: Operations:
 Blood Transfusion: why?
 Fracture of pelvis, spine and femur:

OBS/GYN: D & C
 Ectopic pregnancy:
 Caesarean Section:
 Vacuum Extraction, Forceps
 Retained Placenta
 PPH
 Operations on the uterus e.g.
 Myomectomy
 Cervical circlage (, Shirodkar, Mc Donald)

SOCIAL HISTORY:

Smoking/ Alcohol/other substances (specify)

Risk of S/GBV (Yes/No) If yes Specify: Physical/Pscho-social

Others (specify)
 Health of the Husband/partner

FAMILY HISTORY:

Diabetes
 Hypertension:
 Sickle Cell Disease:
 Epilepsy:
 Twins:
 Others (specify):

PHYSICAL EXAMINATION:

GAIT: _____
 Height: _____ cm Weight: _____ kg

BP: _____ Pulse: _____

Temp: _____ MUAC: _____

Nutritional status*: Normal/ MAM/ SAM

Examine and Comment on the following:

-Oral thrush: **-Anaemia**
 -Teeth: **-Eyes:**
 -Neck: **-Nails:**
 -Breasts: **-Palms:**
 -Legs: **-Jaundice:**
 -Deformities: **-Heart:**
 Lymph Nodes: **Lungs:**
 Herpes zooster:

PELVIC EXAMINATION:

Vulva: Cervix:
 Vagina: Abnormal vaginal discharge (specify):

Comment(s) about previous pregnancies:

Preg-nancy	Year	ABORTIONS		DETAILS OF DELIVERIES						CHILD				
		Below 12 wks	Above 12 wks	Pre-Mature	Full Term	Type of Delivery	Place of delivery	Third Stage	Puer perium	Alive SB/NN	Sex	Birth Weight	Immunisa-tion status	Health Condition
1														
2.														
3.														
4.														
5.														
6.														
7.														

PREVIOUS OBSTETRIC HISTORY

*MAM- Moderate Acute malnutrition; SAM-Severe Acute malnutrition, S/GBV-Sexual and gender based violence

ANTENATAL PROGRESS EXAMINATION

Date	WOA	Fundal Height	Presentation	Position /lie	Relation PP/Brim	Foetal Heart rate	Weight (kg)	BP (mmHg)	Varicose (V) / Oedema (O)	Urine test (Glucose, Protein, gram stain)	HB	Iron / Folic Acid (No. of Pills)	IPT	Net Use	Complaints and Remarks	Return Date	Name of Examiner and Cadre

ROUTINE MEDICINES/INTERVENTION: (indicate Date) Given

Mebendazole: _____
 Tetanus Diphtheria (Td)

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INVESTIGATIONS:
 Blood Group: _____ Rh _____ Hep-B _____
 Sickle Cell Screening Result _____
 Random Blood Sugar _____
 Syphilis Test Results: _____
 B/S for MPs / RDT for Malaria: _____

RISK FACTORS: _____
 Other issues (specify): _____
RECOMMENDATION FOR DELIVERY _____

EMTCT Code

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(Put a YES or NO)
 Any risk for the Mother? _____
 • Adherence counselling _____
 • Referred psychosocial groups (PSS/FSG) _____
 • Partner disclosure support done _____
 • Infant feeding counselling done _____
 • Niverapine Syrup for baby: _____

ULTRASOUND REPORTS:

Date	Gestational Age	Placenta (site and Maturity)	Amniotic Fluid	Complication/ Abnormality	Comments

NOTES/TREATMENT:

*MAM- Moderate Acute malnutrition; SAM-Severe Acute malnutrition, S/GBV-Sexual and gender based violence