



24. REFERRED	<input type="checkbox"/> Reason	<input type="checkbox"/> Reason	<input type="checkbox"/> Reason	<input type="checkbox"/> Reason	<input type="checkbox"/> Reason	<input type="checkbox"/> Reason

25. Certification of Attending Physician/Midwife:

*I certify that the above information given in this form are true and correct.*

SIGNATURE						
PRINTED NAME						

26. PATIENT'S CONFORME

SIGNATURE						
PRINTED NAME						

27. DATE SIGNED

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**PART III-B. PHYSICAL EXAMINATION CONTINUATION**

28. GENERAL SURVEY (PERTINENT FINDINGS PER SYSTEM)

ANTENATAL CARE NO.	7 <sup>th</sup>	8 <sup>th</sup>	9 <sup>th</sup>	10 <sup>th</sup>	11 <sup>th</sup>	12 <sup>th</sup>
Date of visit: (mm/dd/yy)	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
AOG (in weeks):						
Fundic Height (cm):						
Fetal Heart Rate:						

29. VITAL SIGNS:

BP:						
Temperature:						
Weight:						

30. SERVICES PROVIDED

Tetanus Immunization:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MMS:	<input type="checkbox"/> Qty: _____	<input type="checkbox"/> Qty: _____	<input type="checkbox"/> Qty: _____	<input type="checkbox"/> Qty: _____	<input type="checkbox"/> Qty: _____	<input type="checkbox"/> Qty: _____
Iron:	<input type="checkbox"/> Qty: _____	<input type="checkbox"/> Qty: _____	<input type="checkbox"/> Qty: _____	<input type="checkbox"/> Qty: _____	<input type="checkbox"/> Qty: _____	<input type="checkbox"/> Qty: _____
Folic Acid:	<input type="checkbox"/> Qty: _____	<input type="checkbox"/> Qty: _____	<input type="checkbox"/> Qty: _____	<input type="checkbox"/> Qty: _____	<input type="checkbox"/> Qty: _____	<input type="checkbox"/> Qty: _____
Calcium:	<input type="checkbox"/> Qty: _____	<input type="checkbox"/> Qty: _____	<input type="checkbox"/> Qty: _____	<input type="checkbox"/> Qty: _____	<input type="checkbox"/> Qty: _____	<input type="checkbox"/> Qty: _____
Deworming:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Influenza Vaccine:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

31. LABORATORIES REQUESTED

Blood Typing:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CBC:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urinalysis:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIV:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Syphilis:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OGTT:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BUN:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Creatinine:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FBS:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LDH:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SGOT/AST:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SGPT/ALT:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HBA1C:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urine C/S:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ultrasound:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

32. REFERRED	<input type="checkbox"/> Reason	<input type="checkbox"/> Reason	<input type="checkbox"/> Reason	<input type="checkbox"/> Reason	<input type="checkbox"/> Reason	<input type="checkbox"/> Reason

33. Certification of Attending Physician/Midwife:

*I certify that the above information given in this form are true and correct.*

SIGNATURE						
PRINTED NAME						

34. PATIENT'S CONFORME

SIGNATURE						
PRINTED NAME						

35. DATE SIGNED

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